

# BOURNE ORTHODONTICS

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## Acknowledgement of Receipt of Statement of Privacy Practice

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Bourne Orthodontics. The Statement of Privacy Practice described the types of uses and disclosures of my protected health information that might occur during treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Bourne Orthodontics reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

### ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY

YES

NO

SPOUSE ONLY

YES

NO

OTHER (PLEASE SPECIFY): \_\_\_\_\_

YES

NO

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient/Parent/Guardian

OFFICE USE ONLY BELOW THIS LINE

### Record of Acknowledgement not obtained

Reason for denial: \_\_\_\_\_