BOURNE ORTHODONTICS

JASON R. BOURNE, DDS, MS

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:

BIO- FATHER/MOTHER Name :_____ YES ☐ NO ☐

STEP- FATHER/MOTHER Name :_____ YES ☐ NO ☐

GRANDPARENTS: Name :_____ YES ☐ NO ☐

UNCLE/AUNT: Name :_____ YES ☐ NO ☐

OTHER/GUARDIAN (please specify): _____ YES ☐ NO ☐

INDIVIDUALS WE <u>CANNOT</u> SPEAK TO:_____

(Treatment, financial, insurance, & appointment information)

_____		_____	
Print (name of patient)	**Date**	**Signature** (parent/guardian if patient is under 18 years old)	**Date**

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

Reason for denial: _____