JONATHAN THOMAS DDS
Smiles with Aloha

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Jonathan M. Thomas, DDS, Inc. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my 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 the duties and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Jonathan M. Thomas, DDS, Inc. reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable discloses described in the Statement of Privacy Practices, **I hereby specifically authorize disclosure of my Protected Healthcare to the person(s) identified below**. I understand that the default answer is NO. Without indicting YES in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPPA rules.

I hereby specifically authorize disclosure of my Protected Healthcare to the person(s) identified below.

SPOUSE ◯ CHILDREN ◯ PARENTS ◯ GRANDCHILDREN ◯

PRINT NAME: SIGNATURE: DATE:

PATIENT REPRESENTATIVE NAME: SIGNATURE:

PHONE NUMBER: DATE:

OFFICE USE ONLY

ACKNOWLEDGMENT NOT OBTAINED

REASON FOR NOT OBTAINING PATIENT SIGNATURE

WANTED TO CONSULT ANOTHER PERSON BEFORE SIGNING ◯

NEEDED MORE TIME TO REVIEW STATEMENT ◯

PHYSICALLY UNABLE TO SIGN ◯

NO REASON OFFERED ◯

OTHER: ◯

ACKNOWLEDGMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES PROVIDED PRIOR TO TREATMENT?

◯ YES ◯ NO

DATE STATEMENT PROVIDED:_____