



Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the *Statement of Privacy Practices* for the office of Roger A. Flake, DDS in Mill Creek, WA. 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 the 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.

Roger A. Flake, DDS 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:

(Please circle response)

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (Please specify)	YES	NO

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained Provided Prior to Treatment

YES NO

Date Provided: _____

Reason for Denial: _____ Needed more time to review statement of Privacy Practices
_____ Wanted to consult with another person before signing _____ Unable to sign _____
Reason not given _____ Other (explain)

“Never Underestimate the power of your smile”