Lahaina Dental Group

845 Waine`e St, Suite 206, Lahaina, HI 96761
(808) 661-4700
lahainadental@outlook.com

Acknowledgment 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 Lahaina Dental Group, LLC. 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 responsibilities and duties of this office with respect to my protected health information.
Lahaina Dental Group, LLC 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 them to be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

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

Spouse only: ( )Yes ( )No
OR
Any member of my immediate family (Spouse, Children, Children`s Spouses): ( )Yes ( ) No
Any member of my extended family (Parents, Grandchildren): ( ) Yes ( ) No
If so, who?
Other:

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PLEASE COMLETE AND SIGN BELOW

Patient`s name (please print) _____

Patient`s signature (please print) _____

Patient`s personal representative (please print) _____

Personal Representative`s signature _____

Personal Representative`s Phone number: _____

_____
Date

OFFICE USE ONLY BELOW THIS LINE

We attempted to obtain written acknowledgment of Receipt of Statement of Privacy Practices, on _____ but acknowledgment could not be obtained because:
(date)

- Patient refused to sign
- Patient needs more time to review Statement
- Patient wanted to consult another person before signing
- Patient physically unable to sign
- An emergency situation prevented us from obtaining acknowledgment
- Communication barriers prohibited obtaining the acknowledgment
- Other (please specify): _____