KERRY M. O'CONNOR, D.D.S.
2401 Borst Ave., P. O. Box 60
Centralia, WA 98531
360-736-1151

Acknowledgment of Receipt of Statement of Privacy Policies

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Kerry M. O'Connor D.D.S. 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 duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Kerry M. O'Connor D.D.S. 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 visit after the revisions become effective. I may also obtain a revised Statement of Policy Practices by requesting that one be mailed to me.

Additional Disclosure Authority In addition to the allowable disclosures described the Statement of Policy 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**

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

++

Office Use Only Below this Line

RECORD OF ACKNOWLEDGMENT NOT OBTAINED

Provider Prior to Treatment		**Yes**	**No**
Date Provided:			
Reason for Denial:	Needed more time to review		Wanted to consult with another person
	Unable to sign.	Reason not Given.	Other (explain)