Amanda M. Tinkle, DMD PS
117 E. 39th Street
Vancouver WA 98663

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 Amanda M. Tinkle, DMD, PS. 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 offices 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.

Amanda M. Tinkle, DMD, PS, 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 revision 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 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 person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)	
SPOUSE ONLY	❑ YES ❑ NO
ANY MEMBER OF MY IMMEDIATE FAMILY: (SPOUSE, CHILDREN, CHILDREN'S SPOUSES)	❑ YES ❑ NO
ANY MEMBER OF MY EXTENDED FAMILY: (PARENTS, GRANDCHILDREN)	❑ YES ❑ NO
OTHER *(PLEASE SPECIFY)*	❑ YES ❑ NO

_____ _____
Name of Patient (print) Patient Signature

_____ _____
Patient's personal representative (print) Personal Representative's Signature

_____ _____
Representative's telephone number Date

OFFICE USE ONLY BELOW THIS LINE

Acknowledgment 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):_____
  _____