ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you a notice of our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice takes effect 4/15/03, and will remain in effect until we replace it.

You may request a copy of the notice at any time. For more information about our privacy practices, or to receive additional copies, Please contact our office.

I,_____, been offered a copy of this office's Notice of Privacy Practices.

[ ] I declined a copy of this office's Notice of Privacy Practices.
[ ] I have requested and was provided a copy of this office's Notice of Privacy Practices

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PLEASE CHOOSE ONE OF THE FOLLOWING AND SIGN

[ ] I do not wish my information to be discussed with anyone other than myself

[ ] I hereby give Dr. Mueller's office authorization to release my information to the individuals listed below (i.e., spouse, parent, guardian, caregiver, relative, friend)

_____

_____

_____

Signature_____Date_____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign
[ ] Communication barriers prohibited obtaining the acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
[ ] Other (specify)

HIPAA - CORVALLIS PERIODONTICS