Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Sunrise Dental. 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 to this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Sunrise Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the 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 one.

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 information to the persons indicated below. I understand that it is my responsibility to notify the office if I wish to change/update the information listed below:

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

_____ _____

Printed Name of Patient or Responsible Party — Signature of Patient or Responsible Party

_____ _____

Date — Responsible Party Authority (if Patient is Minor or under POA)