D. Michael Ellis, D.D.S.
Meghan J. Lindgren, D.D.S.

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(703) 750-9393

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(703) 250-2214

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 D. Michael Ellis, D.D.S. and Meghan Lindgren, 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 the office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

D. Michael Ellis, D.D.S. and Meghan Lindgren, D.D.S. Reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed 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 persons indicated below.	YES	NO
ANY MEMBER OF MY IMMEDIATE FAMILY		
SPOUSE ONLY		
OTHER (Please Specify)		

I, have received a copy of this office's Statement of Privacy Practices for,

Please **Print Patient's** Name ______________ Please **Sign Guardian's** Name ______________ Date ______________

Adult Patient Signature ______________ Date ______________

For Office Use Only

Record of Acknowledgment not obtained

	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)