ACKNOWLEDGEMENT OF PRIVACY PRACTICES

DR. STEVEN R. ALEXANDER

3620 ENSIGN RD NE

OLYMPIA, WA 98506

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (**HIPPA**). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-partly payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental providers NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such NOTICE OF PRIVACY PRACTICES. I may contact this office at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my required restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME_____DATE_____

SIGNATURE_____

RELATIONSHIP TO PATIENT _____

DEPENDENT FAMILY MEMBERS ALSO COVERED BY THIS ACKNOWLEDGEMENT_____

ADDITIONAL DISCLOSURE AUTHORITY:

- ANY MEMBER OF MY IMMEDIATE FAMILY YES_____ NO_____
- SPOUSE ONLY YES_____ NO_____

FOR OFFICE USE ONLY: WE WERE UNABLE TO OBTAIN THE PATIENTS WRITTEN ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRATICE FOR THE FOLLOWING REASON_____