Andrew M. Nalin, DDS, PS
2210 Kulshan View Drive, Ste 108
Mount Vernon, Washington 98273
360-428-4979

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Nalin Orthodontics, DDS, MS. The Notice 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 the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Nalin Orthodontics, DDS, MS, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY	☐	**YES**	☐	**NO**
SPOUSE ONLY	☐	**YES**	☐	**NO**
OTHER (*PLEASE SPECIFY)*:	☐	**YES**	☐	**NO**

_____ _____

Name of Patient or Personal Representative **Signature** of Patient (Parent/Guardian if Minor)

_____ _____

Date Description of Person Above

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained					
PROVIDED PRIOR TO TREATMENT?	☐	YES	☐	NO	DATE:
☐	NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES.				
☐	WANTED TIME TO CONSULT ANOTHER PERSON BEFORE SIGNING.				
☐	UNABLE TO SIGN.				
☐	REASON NOT GIVEN.				
☐	OTHER (EXPLAIN):				