NADIA GRISHIN, BSDH, DDS

507 N. Sullivan Rd, #20 Spokane Valley, WA 99037 • Phone 509-703-7397 • info@prodigydentalarts.com

ACKLOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Prodigy Dental Arts. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of 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 this office with respect to protect my protected health information. The Statement of Privacy Practices is also posted in the facility.

Prodigy Dental Arts reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If 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 that one be mailed to me.

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.

ANY MEMBERS OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
OTHER (PLEASE SPECIFY) _____	☐ YES	☐ NO

_____ I consent to photography, video recording, and x-rays of my oral structures, and for their educational use in lectures or publications, provided my identity is not revealed.

Name of Patient _____

Signature _____

Date _____