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ACKNOWLEDGEMENT

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 (HIPAA).

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-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

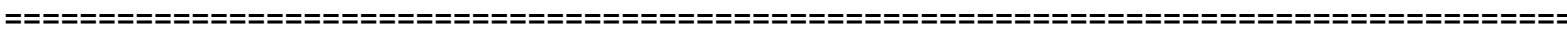
I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

RIGHT TO REVOKE: I understand I have the right to revoke this Consent at any time by giving Dr. Mayes written notice of my revocation. I understand that revocation of this consent will not affect any action Dr. Mayes took in reliance on this Consent before she received my revocation, and that she may decline to treat me or to continue treating me if I revoke this Consent.

Patient Name: _____ Date: _____
(Please print)

Signature: _____

Relationship to Patient: _____



FOR OFFICE USE ONLY: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

_____ The patient refused to sign

_____ Communication barriers

_____ Emergency situation

_____ Other _____