Donald J. "Chip" Paluska, DMD

Privacy Notice Acknowledgment

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name: _____ Date: _____

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed: _____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name: _____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

Signed:_____

File this form in the patient's chart

Chip Paluska, D.M.D *1211 Liberty St. SE, Salem, OR 97302*

****** PERMISSION TO RELEASE CONFIDENTIAL MEDICAL OR DENTAL INFORMATION TO A **** FAMILY MEMBER, FRIEND, OR LEGAL REPRESENTATIVE**

IMPORTANT NOTICE: The law prohibits release of confidential Medical or Dental Information to any entity without the written, voluntary consent of the undersigned patient.

Name of Patient: _____ Date of Birth: _____

☐ **I do not want any information given to anyone other than myself**

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Please select boxes below to specify the information you are authorizing us to communicate.

I authorize Dr. Donald "Chip" Paluska and members of his staff to:

☐ **Discuss information regarding my appointment**

☐ **Leave detailed phone messages**

☐ **Discuss my medical or dental condition**

☐ **All of the above**

Please write in the names of persons who are authorized by you to receive your Protected Health Information (verbally and/or in writing), and their relationship to you (*the patient*):

First and last name	Phone Number	Relationship

This Authorization will expire one year from the date it was signed. Please be prepared to update this authorization once a year which is required by the HIPAA privacy law regulations. This Authorization can be revoked at any time by you (the patient) in writing at any time.

I Understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ _____

(Signature of Patient, Guardian of Patient or Legal Representative) *(Date)*

_____ _____

(Print First and Last Name) *(Date)*