Kim Ierna Kitchen, DDS, PC
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703-836-7000
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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the offices of Kim Ierna Kitchen, DDS, PC. The statement 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 office health care operations. The statement of Privacy practices also describes my rights and the responsibilities and the duties of this office with respect to my protected health information. The statement of Privacy Practices is also posted in the facility.

Kim Ierna Kitchen, DDS, PC 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 Practice by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information as indicated below. *

ANY MEMBER OF MY IMMEDIATE FAMILY	YES or NO
Spouse **ONLY**	**YES or NO**
Telephone messages	**YES or NO**
Recall Post Card	YES or NO
Office Co-Worker	YES or NO
Friend or Associate (specify)	YES or NO
EMAIL & CELL PHONE	**YES or NO**
Other (*please Specify*)	YES or NO

**Failure to check any individual box does not constitute permission, consent, or authorization to disclose my personal health information. Each item of Authorization must be signed or otherwise acknowledged.*

____
Name of Patient or Personal representative

____
Signature of Patient or Personal representative

Date____________________