

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The UW School of Dentistry Clinics and Faculty Practice Plan Notice of Privacy Practices describes how dental and medical information about you may be used and disclosed, how you can get access to this information, and which procedures you may use if you have questions, concerns or complaints.

We are required by law to protect the privacy of your information, provide the Notice of Privacy Practices, and follow the information practices that are described in this notice. If you have any questions, please contact: UW School of Dentistry Privacy Office 206-685-1022.

Please do not write comments on this form. Refer to the "School of Dentistry Clinics and Faculty Practice Plan Notice of Privacy Practices" brochure for instructions to make special requests about your Privacy Rights.

Note: We may change our policies at any time. Any significant policy change will be posted. You may request a copy of this notice from the UW School of Dentistry Privacy Office or at http://www.dental.washington.edu/compliance/pdfs/Dentistry_Note_of_Privacy_Practices.pdf.

By signing below, I agree that I have received the UW School of Dentistry Clinics and Faculty Practice Plan Notice of Privacy Practices.

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION)	DATE
IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIP TO PATIENT AND DESCRIPTION OF THEIR AUTHORITY	

FOR OFFICE USE ONLY: REMARKS for the UW School of Dentistry Clinics and Faculty Practices Plan Notice of Privacy Practices:		
(This section below is to be filled out by UW School of Dentistry staff only)		
<i>We are unable to obtain acknowledgement from this individual at this time, but immediate treatment is needed for the following reason(s):</i>		
" √ "	Reason	Comments
UW School of Dentistry Workforce member Signature: _____ Date: _____		