THREE RIVERS
ORAL AND MAXILLOFACIAL SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to review the Statement of Privacy Practices for the office of Dr. Mohammed-Abdul Khan, DDS, MD, LLC. 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 duties of this office with respect to my protected health information. The Statement of Privacy Practice is also posted in the facility.

Dr. Mohammed-Abdul Khan, DDS, MD, LLC 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.

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 to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES ☐ NO
SPOUSE ONLY	☐ YES ☐ NO
MESSAGE ON WORK TELEPHONE:	☐ YES ☐ NO
MESSAGE ON HOME/CELL TELEPHONE:	☐ YES ☐ NO
EMAIL:	☐ YES ☐ NO
OTHER:	☐ Yes ☐ NO

Our office staff will send you this form to review and sign electronically after you make your first appointment.