FIRST HILL
DENTAL IMPLANT
CENTER

Periodontics & Implant Dentistry

Thomas Kang, DDS

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Dr. Thomas Kang. The Notice 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's health care operations. The Notice Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Thomas Kang, DDS and reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY ☐ YES ☐ NO

SPOUSE ONLY ☐ YES ☐ NO

OTHER (Please specify) ☐ YES ☐ NO

_____ x_____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

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OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

PROVIDED PRIOR TO TREATMENT? ☐ YES ☐ NO

DATE PROVIDED_____

Reason for denial: _____ Needed more time to review
_____ Wanted to consult with another person before signing
_____ Unable to sign
_____ Other (Explain): _____

_____

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