

Kristin J Tarbet, MD
 Oculofacial Plastic, Cosmetic and Reconstructive Surgery
 1810 116th Ave NE Suite D1
 Bellevue, WA 98004

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 Dr. Kristin J. Tarbet. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) 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 PHI. The Statement of Privacy Practices is also posted in the facility.

Dr. Tarbet 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.

In general, the HIPAA privacy rule gives me the right to request a restriction on uses and disclosures of my PHI. I am also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to my office instead of my home.

I wish to be contacted in the following manner (check all that apply):

	OK to leave detailed message	Leave call-back number only	Do NOT call
Home Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cell Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-mail: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

	YES	NO
Any member of my immediate family	<input type="checkbox"/>	<input type="checkbox"/>
Spouse only: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Patient or Personal Representative

 Description of Personal Representative's Authority

THIS BOX IS FOR OFFICE USE ONLY	
Record of Acknowledgement not obtained	
Provided Prior to Treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date Provided: _____	
Reason for Denial:	<input type="checkbox"/> Needed more time to review Statement of Privacy Practices <input type="checkbox"/> Wanted to consult with another person before signing <input type="checkbox"/> Unable to sign <input type="checkbox"/> Reason not given <input type="checkbox"/> Other (explain): _____

Patient:
Date of Service:
Provider: Kristin J. Tarbet, MD