Email

Save

Print

Note: If you are using an internet email such as Yahoo or GMail, you will first need to SAVE your form. You will then need to send the saved form as an email attachment via your email client.

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	☐	☐	☐
Work Telephone	☐	☐	☐
Cell Telephone	☐	☐	☐
Other:_____	☐	☐	☐

Email:_____

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	⦿	○
Spouse only: _____	⦿	○
Other: _____	⦿	○

_____ _____

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?	☐	YES	☐	NO
Date Provided:				
Reason for Denial:	☐	Needed more time to review Statement of Privacy Practices		
	☐	Wanted to consult with another person before signing		
	☐	Unable to sign		
	☐	Reason not given		
	☐	Other (explain):		

Patient:

Date of Service:

Provider: Kristin J. Tarbet. MD