STEVEN C. FELDMAN, D.D.S.
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Suite 8
Wenatchee, WA 98801

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have received a copy of this office's Notice of Privacy Practices. I have been informed of my rights to privacy regarding my protected health and I understand that this information can and will be used to:

> Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
>
> Obtain payment from third-party payers for my health care services.
>
> Conduct normal health care operations such as quality assessment and improvement activities.

I understand that my dental provider has the right to change the Notice of Privacy and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices. I also understand that I may request that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Date: ___________________

Patient name: _______________________________
Signature: _________________________________

Relationship to patient: _______________________

I give permission to share my information with the following.
Spouse: __________________________________
Other: ___________________________________

Patient refused to sign: ______
Communication barriers: ______
Emergency situation: _____