Notice of Privacy Practices Acknowledgement

The Clark College Dental Hygiene Clinic keeps a record of the health care services provided to me. I may ask to see and copy that record. I may also ask to correct that record. Clark College will not disclose my record to others unless I direct Clark College to do so or unless the law authorizes or compels Clark College to do so. I may see my record or get more information about it by contacting the Director of the Department of Dental Hygiene.

The Clark College Notice of Privacy Practices and Protected Health Information (PHI) policy describes in more detail how my health information may be used and disclosed, and how I can access my information.

I have read and understand the Notice of Privacy Practices Acknowledgement.
I give permission for my status/treatment to be shared with my guardian and/or caregiver, if applicable.

Patient Signature (or legally authorized individual signature) ____________________________________ Date ______________

Witness Signature (if signed on behalf of the Patient) ____________________________________ Date ______________