W Banks Allen DMD

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Patient Name: ______________________* ______________________* ____ ______________________
Last First MI Preferred Name

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

It is my understanding that a Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information is posted on the wall of the front office. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact them at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature ____ **Date** ____________

Relationship to Patient: ____________________

You May Release Information To:

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Response Date: ____________