Bentsen & Goodrich DDS
532 N. Elam Ave. Suite B
Greensboro, NC 27403
336-292-4331
Fax 336-316-7022

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have cerain rights to privacy regarding my protected health information. I understand that this information can 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

I acknowledge that a copy of your Notice of Privacy Practices has been made available to me containing a more complete description of the uses and disclosures of my health information. I understand taht this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization 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 pricate information is used or disclosed to carry our treatment, payment or health care operations. I also uinderstand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Additional Authorized Names (if any) _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason