Notice of Privacy Practices Acknowledgment

Bull City Dental
106 West Parrish Street, Suite 1
Durham, NC 27701

I understand that under the Health Insurance & 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.

I acknowledge that I have read your Notice of Privacy Practices and Policies containing a more completed description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy and Policies.

RELEASE OF PROTECTED HEALTH INFORMATION
Besides you, are there any parties that you will specifically allow to receive communications about all or part of your protected health information? (Provide name and Relationship to patient on line below. If none list N/A)**:**

My signature below indicates that I have been given the chance to review the *Notice of Privacy Practices.* My signature means that I agree to allow Bull City Dental to use and disclose my protected health information to carry out all treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Bull City Dental has taken action relying on this consent.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

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

Date	Initials	Reason