Byrd Adkins DDS

3641 S. Soncy Rd. Amarillo, TX 79119 806-372-4072

Notice of Privacy Practices Patient Acknowledgement

Date of Birth:

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provides in detail the uses a	and disclosures of my protecterights and the practice's legal	s written in plain language. The Notice ed health information that may be made by duties with respect to my protected health
 health information. A statement that this in effect. Types of uses and difful following purposes: to a description of each to use or disclose present to use or disclose present authorization of othe authorization and that My individual rights were assumed that 	practice is required to abide isclosures that this practice is reatment, payment, and health of the other purposes for whotected health information with and disclosures that are professed and disclosures that wat I may revoke such authorize	ich this practice is permitted or required hout my written consent or authorization. hibited or materially limited by law. ill be made only with my written
rights have been vevent of such a control of such and the right to inspect to a control of such as a control	violated, and that no retaliator omplaint. st restrictions on certain uses nat this practice is not required to confidential communication and copy protected health in differential protected health information of an accounting of disclosure	
new provisions effective for		Notice of Privacy Practices and to make on that it maintains. I understand that I can on request.
Signature:		Date:

Relationship to patient (if signed by a personal representative of patient):

Patient Name:

Byrd Adkins DDS

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Notice of Privacy Practices Patient Acknowledgement

Patient	Name:	Date of Birth:
provide this pra	received this practice's Notice of Privacy Practices writtenes in detail the uses and disclosures of my protected healt actice, my individual rights and the practice's legal duties vation. The Notice includes:	h information that may be made by
•	A statement that this practice is required by law to maintal health information. A statement that this practice is required to abide by the tin effect. Types of uses and disclosures that this practice is permitt following purposes: treatment, payment, and health care of A description of each of the other purposes for which this to use or disclose protected health information without my A description of uses and disclosures that are prohibited of A description of other uses and disclosures that will be made authorization and that I may revoke such authorization. My individual rights with respect to protected health information to:	erms of the notice currently ed to make for each of the operations. practice is permitted or required written consent or authorization. or materially limited by law. ade only with my written
	 The right to complain to this practice and to the Secretarights have been violated, and that no retaliatory action event of such a complaint. The right to request restrictions on certain uses and disinformation, and that this practice is not required to agree The right to receive confidential communications of protection to inspect and copy protected health informated The right to amend protected health information. The right to receive an accounting of disclosures of protection to obtain a paper copy of the Notice of Privacupon request. 	s will be used against me in the sclosures of my protected health ree to a requested restriction. tected health information.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can

Date:

obtain this practice's current Notice of Privacy Practices on request.

Relationship to patient (if signed by a personal representative of patient):

Form # PRV1-3