

**Pampa Dental Arts, PLLC**  
**2427 N. Hobart**  
**Pampa, Texas 79065**  
**(806) 665-0921**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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.

A copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information has been made available to me. 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 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.

Patient Name (Printed): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: X \_\_\_\_\_

Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

I authorize Pampa Dental Arts PLLC, Christopher Mohr DDS, and staff members to discuss and/or release information regarding my dental treatment, records and bills to the individuals listed below until such time I revoke the authorization in writing.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**OFFICE USE ONLY**

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

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_