Chris Hartung, DDS
1819 E. Innes Street
Salisbury, NC 28146
704-762-9669

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

Patient Name_____ Date_____

I acknowledge that I have reviewed the NOTICE OF PRIVACY PRACTICES, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions that I request.

REFERRAL INFORMATION
If you were referred to our office by another patient or medical office, may we include your name when thanking that patient? _____ yes _____ no

AUTHORIZATION FOR RELEASE OF INFORMATION
Our office is authorized to release protected health information about the above named patient to the entities listed below.

_____

_____

_____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Date

Once this page has been signed, this will be placed in your records as written acknowledgement of receipt of the NOTICE OF PRIVACY PRACTICES.

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NOTICE OF PRIVACY PRACTICES

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

Subject to certain requirement, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our polices, we will change our notice and make a copy available to you. You can also request a copy of our notice at any time. For more information about our privacy practices, contact our office.

YOUR RIGHTS
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

The following is a brief description of how you may exercise these rights

COMPLAINTS
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the US Department of Health and Human Services.

OUR LEGAL DUTY
We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the practices that are described in this notice.

If you have any questions or complaints, please contact our office.