Robert L. Rodriguez, D.D.S.
Randall P. Westman, D.D.S.
NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 HIPPA), understand 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 received your Notice of privacy practices containing a more complete 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 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: _____

Relationship to Patient: _____ Date: _____

Signature: _____

OFFICE USE ONLY
I attempted to obtain patient's signature in acknowledgement on the Notice of Privacy Practice Acknowledgment, but was unable to do so as documented below:

Date_____ Initials: _____ Reason: _____

ROBERT L. RODRIGUEZ, DDS
DENTISTRY WITH A SMILE

7434 Blanco Road * San Antonio, Texas * 210-341-6824