Lauren Taylor Irvin DDS PLLC
2001 North Church St. Suite 211
Greensboro, NC 27405
336-292-4331 336-316-7022(fax)

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can 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 a copy of your **Notice of Privacy Practices** has been made available to me 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

At my request, I authorize Lauren T. Irvin, DDS, PLLC to disclose my protected health information to:

Authorized Names (if any): _____

Relationship to Patient: _____

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed. This will include, but not limited to, appointment day/time, treatment, and financial concerns. This gives the office permission to use any contact written on the patient registration form.

____ Cell phone ____Work phone ____ Home phone

____ Home email ____ Work email ____ Any of the above

Print Patient name:

_____

Signature of patient or legal guardian: _____ **Date:**

_____

_____Patient refused to sign HIPPA consent.