RECEIPT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, ____, or my guardian, has received the Notice of Privacy Policies for Christopher Walker, DDS, PA "Doing Business As" Benson Dentistry. I do not have any restrictions (unless indicated below) as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Requested Restriction (if any): ____

PERMISSION TO DISCUSS PATIENT HEALTH INFORMATION

I hereby give my permission to the person(s) listed below to receive information about the care of the above-named patient:

NAME	RELATIONSHIP
_________________________________	______________________________
_________________________________	______________________________
_________________________________	______________________________

I give permission for Benson Dentistry to contact me regarding appointments, treatments or financial purposes using the following methods:

__ Leave a message with person answering the phone

__ Phone/Voice Mail/Answering Machine

__ Text Messaging

__ Email

__ Postcard/mailing

__ Other: ____

By signing this form, I am consenting to allow Benson Dentistry to use and disclose my personal healthcare information to carry out treatment plan options. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Benson Dentistry may decline to provide treatment to me.

Printed Patient Name __________________________________ **Date:** _______________

Signature of Patient or Legal Guardian ____

Print Legal Guardian Name (if applicable) _____________________________________

Legal Guardian's Relationship to Patient ______________________________________

9-2020

Dr. Christopher Walker, *Dentist & Owner* | (919) 894-4195 FAX: (919) 894-5416

405 S Market Street | P.O. Box 278 | Benson, NC 27504

www.bensondentistry.com | info@bensondentistry.com