Travis Hammons, D.D.S.
10740 Research Blvd. Ste #125
Austin, Texas 78759
95120 795 -9960

Notice of Health Information Practices Acknowledgment Form

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of this policy and return it to our receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of Travis Hammons, D.D.S. I understand that the organization reserves the right to change their notice and practices prior to implementation will mail a copy of any revised notice to the address I have provided. 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 requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

Name of Patient

_____

Signature of Patient

_____

Date