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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We use and disclose health information about you for treatment, payment, and healthcare operations.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited expectations.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information.

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or to a alternate location.

Amendment: You have the right to request that we amend your health information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

(Please Print Name) _____

(Signature) _____

(Date) _____

**you may refuse to sign this acknowledgement*