McConnell
ORTHODONTICS

Your Privacy Is Important to Us

Acknowledgment of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of McConnell Orthodontics, PC. I hereby authorize, as indicated by my signature below, McConnell Orthodontics, PC to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Patient Name Address

_____ _____

Responsible Party Signature Date

Please check your preferred means of communication:

❑ You may contact me at my home telephone number _____

❑ You may contact me at my mobile telephone number _____

❑ You may contact me at my work telephone number _____

❑ You send me an unencrypted email/text message at: _____

❑ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____
4. _____ Date Added / Removed: _____

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For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

❑ Individual refused to sign

❑ Communication barriers prohibited obtaining the acknowledgment

❑ An emergency situation prevented us from obtaining the acknowledgment

❑ Other (Please Specify) _____

Staff person Initials _____