



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 from.

Print Patient Name

Address

Responsible Party Signature

Date

Please check your preferred means of communication:

- Radio button options for communication preferences: home telephone, mobile telephone, text message, work telephone, email, and other.

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

- Numbered list for authorized persons with fields for name and Date Added/Removed.

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:

- Radio button options for reasons for lack of acknowledgment: individual refused, communication barriers, emergency situation, or other.

Team Members Initials _____