McCONNELL
FAMILY DENTISTRY

Drs. Mark and Cindy McConnell
118 Kendra Drive
Mooresville, NC 28117
704-660-3540

version: July 2004

Name of Patient: _____
Address of Patient: _____
Date of Birth: _____ Social Security #: _____

I hereby authorize McConnell Family Dentistry to release protected health information (medical, billing, and demographics) for the purpose of diagnosing and providing treatment, obtaining payment, and conducting healthcare operations in accordance with our Notice of Privacy Practices. I have carefully reviewed the Notice of Privacy Practices which outlines how McConnell Family Dentistry may need to use my protected health information.

I have been given for review the Notice of Privacy Practices at the time I received this consent, and I understand that I may request a copy to keep by calling or visiting the office. McConnell Family Dentistry reserves the right to revise the Notice of Privacy Practices and I may request a copy at any time.

I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken on it. Revocations should be submitted to the office address and will be effective when received. In the event that I revoke this consent, I understand that diagnosis and treatment may be affected.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I UNDERSTAND THAT I MAY BE ASKED TO SIGN A SECURE SIGNATURE PAD IN PLACE OF THIS PAPER SIGNATURE TO BE PLACED IN MY ELECTRONIC RECORD (CHART).

Signature of Patient: _____ Date: _____
Signature of Witness: _____

If the patient is a minor or is unable to give permission to sign the foregoing because of physical disability or mental incompetence, complete the following:

Signature of Patient's representative: _____
Relationship to Patient: _____