Dr. Brittany Winn McKinley, DMD, PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________ have received or was given an opportunity to review a copy of this office's Notice of Privacy Practices.

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Name (print)

________________________________ ________________________________
Signature Date

For Office Use Only
Written acknowledgement of receipt of our Notice of Privacy Practices was attempted but not obtained because:
__Individual refused to sign __Communication barriers __An emergency situation __ Other

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Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use disclose your Protected Health Information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Practices to gain a clear understanding of how we may use and disclose your Protected Health Information.

For questions concerning our Notice of Privacy Policies or to obtain a copy of it please contact: Susan, Compliance Officer / Patient Coordinator at (270) 926-3199.

I, ________________________________ have had full opportunity to read and consider this form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, appointment information, and health care operations.

If this consent is signed by a personal representative on behalf of the patient please complete the following:

____
Personal Representative's Name

____
Relationship to Patient