

PATIENT PRIVACY AUTHORIZATION FORM

Our Notice of Privacy Practices provides information regarding our protection of dental/health information and how Timothy M. McSweeney, D.M.D. may use and disclose this information. You have the right to review our notice prior to signing this form and/or have the right to a copy of the written notice. We are not required to agree to this request, but if we do, we are bound by this agreement. It is stated that revisions may be made to the Privacy Practices in the future. You are entitled to receive a copy of the revised notice. You have the right to request that we restrict how we use or disclose our protected dental/health information for treatment, payment, or dental care operations.

By signing this form, you authorize our use and disclosure of your protected dental/health information for treatment, payment, and/or dental/healthcare needs. You have the right to revoke this, in writing, except where we have already made disclosure based upon your prior authorization.

I hereby authorize Timothy M. McSweeney, D.M.D. the use and disclosure of my personal protected dental/health information as specified in this authorization form. I understand it is voluntary and that this disclosure may be due to my personal request. I understand further that if the organization authorized to receive the information is not a dental/healthcare plan or dental/healthcare provider, the released information may no longer be protected by federal or state privacy regulations.

Patient Name (Please Print): _____
Patient Address: _____
Signature of Patient/Parent/Guardian: _____ Date: _____
Relationship to Patient (if Parent/Guardian): _____

I hereby authorize Timothy M. McSweeney, D.M.D. to disclose my personal protected dental/health information as specified in this authorization form to the following personal contacts (ex: mother, father, spouse, etc)

_____	_____
Authorized Person	Relationship
_____	_____
Authorized Person	Relationship

I understand/exercise my right of refusal to sign this authorization. By doing so, I further understand any need for disclosure of protected dental/health information for purposed including (but not limited to) treatment, referral for consult, extraction and/or other surgical procedure, payment, transfer due to move, and/or other dental/healthcare needs may not be covered under this Privacy Act and may not be performed.

Patient Name (please print): _____
Signature of Patient/Parent/Guardian: _____ Date: _____
Relationship to Patient (if Parent/Guardian): _____

(FOR OFFICE USE ONLY)

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

Individual refusal. An emergency situation prevented us from obtaining authorization.
 Communications barriers prohibited obtaining this authorization. Other (Please specify): _____.

PRIVACY OFFICER SIGNATURE/DATE: _____

Other trained employee signature/date: _____