**Lauren Taylor McNeil DDS PLLC**
**2001 North Church St. Suite 211**
**Greensboro, NC 27405**
**336-292-4331  336-316-7022(fax)**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that a copy of your **Notice of Privacy Practices** has been made available to me containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

At my request, I authorize Lauren T. McNeil, DDS, PLLC to disclose my protected health information to:

**Authorized Names (if any):** _____

**Relationship to Patient:** _____

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed. This will include, but not limited to, appointment day/time, treatment, and financial concerns. This gives the office permission to use any contact written on the patient registration form.

____ Cell phone  ____Work phone  ____ Home phone

____ Home email  ____ Work email  ____ Any of the above

**Print Patient name:** _____

**Signature of patient or legal guardian:** _____ **Date:** _____

_____**Patient refused to sign HIPPA consent.**