NOTICE OF PRIVACY PRACTICES
Acknowledgement of Notification
Acceptance of Agreement
and
Medical Release Form

Dr. Thomas A. Conner
And Associates
9510 Iron Bridge Road, Suite 100
Chesterfield, VA 23832

Tel: (804) 768-7600 Fax: (804) 768-0115

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I also hereby grant the office of Dr. Thomas A. Conner permission to seek and obtain any medical records deemed necessary to complete dental treatment for me from:

Physicians name: _____

Patient's Name:_____
(please print)

Signature:_____
(signature of patient , parent/legal guardian)

If patient is unable to sign or is a minor, complete the following:

Relationship to patient:_____

Print Name:_____

Signature: _____