

**FAMILY
DENTAL
PRACTICE**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: INDIVIDUAL GIVING CONSENT

(LABEL INSERTED HERE)

SECTION B: TO THE INDIVIDUAL—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as set forth in our Privacy Practices Notice. Your HIV test results, if any, may be disclosed to persons and /or circumstances specified in Wisconsin Statutes 252.15(5)(a). A listing of those persons and /or circumstances is available upon request. Under Wisconsin law, this form is to obtain an individual's written permission for (a) our use of the individual's patient health care records, HIV test results and mental health treatment records to carry out treatment, payment activities and health care operations and (b) our disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care operations and (c) the listing of an individual's general condition in our facility directories and (d) our disclosure of you patient health care records, mental health treatment records and HIV test results for disaster relief purposes as permitted by law and to people involved in your care of payment for that care. This form should not be used to obtain written permission for the disclosure of mental health treatment records or HIV test results unless the name of the recipient is listed on this form.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on you behalf to pick up filled prescriptions, medical supplies, radiographs or other similar forms of protected health information.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sue Buchholtz
Phone: (920) 261-8228 Fax: (920) 261-8219
1518 Doctors Court
Watertown, WI 53094

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

