APPLETOWN DENTAL CARE – DR. DAVID R. SMITH
1707 S. Oneida Street
Appleton, WI 54915

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patients Name _____

Address_____City _____Zip____

Telephone/Cell Phone_____

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 options.

Notice of Privacy Practices: By signing this form you acknowledge receipt of the Notice of Privacy Practices. 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. We encourage you to read it before signing this Consent.

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

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at our office.

Right to revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or 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 protected health information to carry out treatment, payment activities and healthcare operations.

Signature_____**Date**_____

If this consent is signed by a personal representative on behalf of a patient, please circle one:

Mother **Father** **Other**_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I Revoke my consent for 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 took in reliance on my Consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature_____Date_____

Purpose: This form is to obtain an individual's written permission under Wisconsin law. By signing this form, you will consent to our use of your dental records to carry out treatment, payment activities and healthcare operations as set forth in our Privacy Practices Notice.

Effects of Declining Consent: This consent is a condition of treatment by us. If you decide not to sign this consent, we may decline to treat you.

PLEASE READ AND COMPLETE THE FOLLOWING

Privacy Practices Notice: You have the right to read our Privacy Practice Notice before you sign. Our Notice provides a description of our treatment, payment activities and healthcare operations of your protected health information. You may obtain a copy of our office's Notice of Privacy practices at any time.

Persons Involved in Care: By signing this form you will consent to the use of your dental records to the following persons, including those involved in your care or payment for care.

_____Spouse _____Mother _____Father _____Other

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 your behalf to pick up prescriptions, medical supplies, X-rays or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment and healthcare operations as set forth in our Privacy Practices Notice. We may also disclose your dental records for disaster relief purposes as permitted by law.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice to our office. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

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

SIGNATURE_____**DATE**_____

If this consent is signed by a personal representative on behalf of the patient, please circle one:

Mother Father Other_____