

WASHBURN FAMILY DENTISTRY

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE AND WISCONSIN CONSENT

SECTION A:

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone: _____ E-Mail: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from Washburn Family Dentistry.

Signature: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: X _____

Relationship to Individual: X _____

SECTION C: Good faith efforts to obtain the individual's signature on this form: _____

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

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

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care 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 is available upon request. We encourage you to read it if you have any questions before signing this consent.

The Uses and Disclosures Being Authorized:

Our Use of Medical Information: By signing this form, you will consent to our use of your patient health care records, mental health treatment records, and HIV test results to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notices.

Facility Directory and Persons Involved in care: By checking the item below, you indicate your consent to our disclosure of your patient health care records, mental health treatment records, and HIV test results for disaster relief purposes as permitted by law, and to the following persons, including those involved in your care or payment for that care.

X _____ X _____
X _____ X _____

We may use professional judgment and our experience with common practice to make sure inferences of your best interest in allowing a person acting on your behalf to pick up filled 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 patient health care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice. Your HIV test results, if any, may be disclosed to persons and/or under circumstances specified in Wisconsin Statutes section 252.15 (5)(a). A listing of those persons and/or circumstances is available upon request.

Revocation:

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. 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 or to continue treating you if you revoke this consent.

Washburn Family Dentistry
16 E Bayfield Street, PO Box 415
Washburn WI 54891

Individual's Signature:

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am acknowledging receipt of the Privacy Practice Notice and an confirming ny written permission for the disclosure of my protected health information as described in this form.

Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this consent, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____