Harris Family Dental S.C.

WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin Law for our use and disclosure of the patient's dental care records to carry out treatment, payment activities, and health care operations.

SECTION A: INDIVIDUAL GIVING CONSENT

Patient/Legal Guardian Name: _____

Address: _____

Patient name: _____ Date of Birth: _____

Is there any other person with whom we may discuss your dental health?_____

_____	_____	_____
Persons Name	Relationship	Phone Number

TO THE INDIVIDUAL: Please read the following and complete the information requested

Privacy Practices notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides description of our treatment, payment activities, and health care operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your 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.

SECTION B: THE USES AND DISCLOSURES BEING AUTHORIZED.

Our Use of Dental Health Information: by signing this form you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Signing This Consent Is Not Limited to, but Does Allow us to:

*Send you appointment reminder post cards, emails or texts/calls
*Leave voice mail or recorded messages regarding appointments and or balances
*Leave voice mail or recorded messages regarding the need for pre-medication or medication required
*Communicate by phone, text/calls, email, fax or in writing with your insurance company
*Communicate by phone, email, fax, or in writing with specialist involved with your care
*Communicate dental concerns and information with responsible family member, spouse or guardian
*Communicate information regarding your care with pharmacies designated by you

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.

Signature: _____ Date: _____

In signing this form I am confirming that all the information that I have provided on the Health History Form is true and up to date.

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. Please understand that 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.

Harris Family Dental S.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____ , have reviewed a copy of this office's Notice of Privacy Practices.
(print guardian, or patient name if 18yrs or older)

I understand a copy is available to take home if requested.

_____
(Please Print Patient Name)

_____
(Guardian or Patient Signature)

_____
(Date)

For Office Use Only

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

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

_____

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