
DE PAS FAMILY DENTAL CARE, S.C.

FEDERAL & WISCONSIN CONSENT

SECTION A: INDIVIDUAL GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

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

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 accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION B: 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 to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care. By checking the box below, you indicate your consent to:

Our disclosure of your patient health care records for disaster relief purposes as permitted by law, and to the following persons, including those involved in your care or payment for that care.

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 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.

SECTION C: 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 you or to continue treating you if you revoke this consent.

Contact Person: Theresa Rosenbaum

Telephone: (920) 968-1900

Fax: (920) 831-0059

E-mail: drdave@yourdds.org

Address: 1431 Province Terrace, Menasha, WI 54952

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 confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Individual: _____

Include completed form in the individual's records.

Copy to Privacy Official.