Dr. Nicholas Sabel Dr. Tom Volm Dr. Dennis Hanna
15738 W. National Ave
New Berlin, WI 53151

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

NAME: _____
ADDRESS: _____
TELEPHONE: _____

Acknowledgement of Receipt of Privacy Practice Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

SIGNATURE: _____ DATE: _____
If personal representative signs this authorization on behalf of the individual, complete the following:
PERSONAL REPRESENTATIVES NAME: _____

RELATIONSHIP TO THE INDIVIDUAL: _____

GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT
Describe your good faith effort to obtain the individual's signature form:

_____

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

_____

SIGNATURE:
I attest that the above information is correct.
SIGNATURE: _____ DATE:_____
PRINTED NAME: _____ **TITLE** _____

WISCONSIN HIPAA CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) 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. This form should not be used to obtain written permission for the disclosure of mental health records or HIV test results unless the name of the recipient is listed on this form.

Individual Giving Consent:
NAME: _____

ADDRESS: _____

TELEPHONE: _____

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

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

Privacy Practices Notices: 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 healthcare operations, of the uses and disclosure 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. (OVER)

The uses and disclosure 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 Notice.

Facility Director and Person Involved in Care. By checking the boxes below, you indicate your consent to:

- ✓ Our listing of my general condition in our facility directories
- ✓ 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.

List names and phone numbers of people we can contact regarding your care or in case of emergency:

1) _____
2) _____
3) _____
4) _____

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 healthcare 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 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 you or to continue treating you if your revoke this consent.

Contact Office: The Art of Modern Dentistry
15738 W. National Ave
New Berlin, WI 53151
Phone: 262-784-2110 Fax: 262-784-9451

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 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: _____

Revocation:

I, _____, hereby revoke the above Privacy Practice Notice consent form.

Date: _____

Change of Consent:

I, _____, wish to change the people listed on this consent form who I had previously given this office permission to contact. In order to do so, I choose to void this form and fill out a new one with updated names. I understand that as of this date I sign this, it will be null and void.

Signature: _____ Date: _____