RESTORATION DENTAL

BRIDGET MACKEY, DDS

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Glendale, WI 53217

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

Patient Name: _____

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 out 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 or other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION A: 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 Notices.

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

☐ YES ☐ NO **There are others I would like to have access to my records and information.**

Please list the person(s) you would like involved in your care on the line below:

_____

☐ YES ☐ NO **I give Restoration Dental consent to speak with and share information including x-rays and medical records with healthcare providers involved in my treatment.**

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. Base on this professional judgment we may share/discuss information directly relevant to treatment options, costs and payment options with family members or friends who are involved with your care. (Statute 45 CFR 164.510(b))

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 activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION B: 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 this 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 if you revoke this consent.

SECTION C: Individual giving consent

Name: _____ Patient / Guardian / Parent
(Please Circle One)

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: _____

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