FOX VIEW DENTAL S.C.

WISCONSIN CONSENT

(Wisconsin)

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our 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 treatment records or HIV test results unless the name of the recipient is listed on this form.

SECTION A: Individual giving consent.

Name: ______________________________ Social Security Number: (opt)__________________

Address: ______________________________ Telephone: ______________________________

____________________ZIP____________

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, 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.

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.

______________________________ ______________________________

______________________________ ______________________________

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. 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.

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 Office: Fox View Dental S.C., 2310 Oak Ridge Circle, De Pere WI 54115
Telephone: (920) 336-4201 Fax: (920) 336-0340

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: ________________

PLEASE RETURN COMPLETED FORM TO BE INCLUDED IN YOUR RECORDS