

Michael C. Clausius DDS
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 dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's patient dental care records to carry out treatment, payment activities, and health care operations.

SECTION A: Individual giving consent

Name: _____

Address: _____

Telephone: _____ E-mail: _____

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 dental office's Notice of Privacy Practices 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 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.

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. Please list the person(s) you would like 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: Michael C. Clausius DDS
Telephone: (414)762-0200
Address: 8725 S HOWELL AVE
OAK CREEK, WI 53154

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. Send copy to the Privacy Official.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this office's Notice of
Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

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

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)