

## **Monona Dental, S.C. HIPPA Consent**

Purpose: This form is to obtain an individual's written permission under the law for our use of the individual's dental care records to carry out treatment, payment activities, healthcare operations, and our disclosure of the individual's dental care records to carry out treatment, payment activities and healthcare operation.

Section A: Individual giving consent:

Name: \_\_\_\_\_

Patient Name: (If different from above) \_\_\_\_\_

**TO THE INDIVIDUAL:** Please read the following and complete the information requested. Effect of Declining Consent: This consent 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 user and disclosures we may make of your protected health information and other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices is available in our office. We encourage you to read it carefully and completely before signing this consent.

Section B: The uses and disclosure 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 person(s) 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.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

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

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 of this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating if you revoke this consent

Contact: Richard H. Teteak, D.D.S.

Telephone: 608-222-9146

Address: 502 River Place, Monona, WI 53716

**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/parent on behalf of the individual, please complete the following:

Personal Representative's /Parent Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_ Date: \_\_\_\_\_