Drs. Landon & Sirotinski
8430 W. Forest Home Ave.
Greenfield, WI 53228
(414) 425-2466

WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (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.

SECTION A: Individual giving consent.

Name_____ Patient name (if different)_____

Address_____ Phone ( )_____

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 Practice 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 by 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 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 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 above. 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.

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, complete the following:

Personal Representative's/Parent Name:_____ Relationship:_____