CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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

SECTION A: Individual giving consent.

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

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 reat it carefully and completely before signing this consent.

SECTION B: The uses and disclosures being authorized.

Our Use of Patient Information: By signing this form, you consent to our use of your patient records to carry out treatment, payment activities, and healthcare operations as set forth in our Privacy Practices Notice. We may use professional jusgement 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 prescriptions, supplies, x-rays, or other similar forms of protected health information.

Persons Involved in Care. By checking the line below, you indicate your consent to: Our disclosure of your patient health care records to the following persons, including those involved in your care of payment for that care:

Name person here (other than self): _____

Our Disclosure of Patient Information: By signing this form, you consent to our disclosure of your patient records to carry on treatment, payment activities, and healthcare operations as set forth in our Privacy Practices Notice.

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 our 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 or to continue treating you if you revoke this consent.

J. Charles Mesec, DDS
240 N. Main Street
Burlington, WI 53105

INDIVIDUALS 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 the consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representatives Name: _____

Relationship to Individual: _____