VALLEY ENDODONTICS, LTD.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
&
CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent : By signing this form, you will acknowledge receipt of this office's Notice of Privacy Practices and you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You may refuse to sign this consent.

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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Contact Office : Valley Endodontics, Ltd. – Attn: Lu Ann Lee
1100 N. Lynndale Drive Appleton, WI 54914
Telephone: (920) 731-4484 Fax: (920) 731-2889 E-mail: valleyendo@sbcglobal.net

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 that I have received a copy of this office's Notice of Privacy Practices and am giving 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: _____

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date:_____

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ADDENDUM TO NOTICE OF PRIVACY PRACTICES

THIS ADDENDUM TO THE NOTICE OF PRIVACY PRACTICES SETS FORTH WISCONSIN PRIVACY REQUIREMENTS THAT ARE IN ADDITION TO THOSE IN OUR NOTICE OF PRIVACY PRACTICES. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by Wisconsin law to maintain the privacy of your health informationUSES AND DISCLOSURES OF HEALTH INFORMATION .

Healthcare Operations : Under Wisconsin law, we must have your written permission before we may use and disclose your health information in connection with healthcare operations other than management of our medical records and certain auditing and review activities by staff committees and review organizations.

To Your Family and Friends and Persons involved in Your Care : Under Wisconsin law, we must have your written permission before we may disclose your health information, other than limited identifying information, to your family, friends, or other persons involved in your care.

Abuse or Neglect: Under Wisconsin law, we must have your written permission before we may disclose your health information to the appropriate authorities if we believe you are the victim of domestic violence or other crimes. We may report child abuse and the abuse or neglect of a vulnerable adult as allowed by Wisconsin law.

PATIENT RIGHTS

Restriction : While we are allowed to determine whether we agree to your request to restrict our use and disclosure of your protected health information, Wisconsin law requires that we honor certain restriction requests by private pay patients relating to research or the release of information to government agencies.

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