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# WISCONSIN CONSENT
# (Wisconsin)

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

**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
Patient Name: (If different than above)

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.

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.
Children over the age of 18 must list their parents or no information can be disclosed. Also please list any spouse you may want to know about your treatment.

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 fo 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 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.

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 of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____