

RACINE DENTAL GROUP, S.C. / DIRECT DENTAL SERVICE PLAN, INC.

WISCONSIN CONSENT

SECTION A: INDIVIDUAL GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

Purpose of Consent: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's patient health care records, HIV test results, and mental health treatment records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care operations. This form should not be used to obtain written permission for the disclosure of mental health treatment records or HIV test results unless the name of the recipient is listed on this form.

THIS CONSENT ALLOWS US TO TREAT YOU, FILE YOUR CLAIMS, AND STORE YOUR HEALTH INFORMATION IN YOUR CHART AND IN OUR COMPUTERS.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare 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.

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. This consent allows us to file your claim and to receive payment from your insurance carrier. Without your consent we cannot file your claim.

SECTION B: THE USES AND DISCLOSURES BEING AUTHORIZED.

Our Use of Medical Information: By signing this form, you will consent to our use of your patient health care records, mental health treatment records, and HIV test results to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

By signing this form you consent to our disclosure of your patient health care records, mental health treatment records, and HIV test results for disaster relief purposes as permitted by law, including those involved in your care or payment for that care. You also consent our listing of patient health care information in your chart and on our computer systems. To be used only for the purpose of treatment, payment activities, and health care operations.

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 of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your patient health care records to carry out **treatment, payment activities, and health care operations** as set forth in our Privacy Practices Notice. Your HIV test results, if any, may be disclosed to persons and/or under circumstances specified in Wisconsin Statutes 252.15 (5) (a). A listing of those persons and/or circumstances is available upon request.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Telephone: (262) 637-9371 Fax: (262) 637-0576 E-mail: HIPAAPRIVACYOFFICER@RACINEDENTALGROUP.COM

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 Consent form, I am confirming my written permission for the disclosure of my protected health information, as described in this form (to carry out treatment, payment activities, and health care operations).

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT