Hauge Dental Clinic
CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name:___________________________________**Social Security Number:**_______________________
Address:____
Telephone:_________________________________**Cell Phone:**_________________________________

Section B: To the patient – Please read the following statements carefully

Purpose of Privacy Practices: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

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. Upon request, a copy of our Notice accompanies this Consent, otherwise it is posted on the wall in the waiting room. 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.

HAUGE DENTAL CLINIC
301 South 6th Street Hwy 35
Centuria, WI 54824

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received our revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, __________________________________have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information 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.

Include completed Consent in the patient's chart.