Williams and Pearce Family Dental
100 N Church St ≈ Po Box 522
Richland Center WI 53581

Patients Name:

HIPAA

This form is to obtain an individual's written consent and authorization from all patients with whom we have a direct treatment relationship before using or disclosing protected health information (PHI) for treatment, payment or other health care operations (TPO).

Please read the following and complete the information requested:

Effect of Declining Consent: This consent and authorization is a condition of your treatment plan by us. If you decide not to sign to this consent and authorization we may decline treatment to you in our facility.

Privacy Practice Notice: You have the right to read our Privacy Practice Notice (available at the front desk) before you decide whether to sign this consent. Our notice provides a description, uses and/or disclosure of our treatment, payment activities, and health care operations. We encourage you to read the Privacy Practice Notice carefully and completely before signing the consent.

Persons involved in Care: You may list any other individuals that you consent to our use of your protected health information (PHI) for treatment, payment or other health care operations (TPO).

Please list name(s):

DISCLAIMER: We may use professional judgment and our experience with common practice to make a reasonable inference of your best interest in allowing a person acting on your behalf to pick up filled prescription, medical supplies, x-rays, or other similar forms of protected health information.

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 before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Disclosure of Medical Information: By signing this form you consent to disclosures stated above.

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 with my written permission for the disclosures of my protected health information as described in this form.

Signature: ______________________________ Date: ____________________

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:
Personal Representative's / Parent Name: ___________________________________

Relationship to individual: ____

For office use only

We attempted to obtain written acknowledgement but acknowledgement could not be obtained because: ☐ Refusal Patient:_____________☐ Communications Barrier ☐ Emergency