Town & Country Dental
N168 W20566 Main Street
Jackson, WI 53037
(262)677-2224

Consent for Use and Disclosure of Health Information & Acknowledgement of Receipt of Notice of Privacy Practices

Section A: Patient Giving Consent

Chart #. _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Section B: To thePatient, Please read the following statement carefully

Purpose of Consent: 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 as set forth in our Privacy Practices Notice.
Effect of Declining Consent: This consent is a condition of your treatment by us. If youdecide not to sign this consent, we must decline to treat you.
Notice of Privacy Practices: You have theright to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we maymake 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 berfore 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 practieces, we will issue a revised Noticeof Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting;
Contact Office: Peter C. LaBudde DDS
Telephone: 262-677-2224 Fax: 262-677-3620 Email: tcdpcldds@ameritech.net
Address: N168 W20566 Main Street, Jackson, WI 53037
Right to Revoke: This Consent is effective until you revoke it. You may revoke this Consent at any time by giving us written notice of your recovation submitted to the Contact Office Listed above.Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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ACKNOWLEDGEMENT

I have had full opportunity to read and consdier 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.

In addition to our right to perform insurance claims, billing, and collection activities, is there anyone with whom we may communicate regarding your treatment at Town & Country Dental - i.e. spouse, parent, care-givers, etc. Please list below:

Personal Representative's Name:

Relationship to Patient:

You are entitled to a copy of this consent after you sign it.

Response Date: