KENDRA S. SCHAEFER, DMD, LLC
PROSTHODONTICS OF MADISON

HIPAA OMNIBUS RULE AND WISCONSIN CONSENT FOR HIPAA PRIVACY
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT & RELEASE FORM

PURPOSE: This form is to obtain an individual's permission under Wisconsin law for (a) our use of the individual's patient health care 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 consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you. 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 health care operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your protected health information.

In signing this HIPAA Patient Acknowledgement & Consent form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

How do you wish to be addressed when called from the reception area (please check one):

_____by First Name Only _____ by Proper Surname (Mr/Mrs. Last Name) _____ Other: _____

I authorize contact from this office to confirm my appointments, treatment and billing/payment information via:

_____ Cell Phone _____Home Phone _____Work Phone

Please list any other parties who can have access to your health information (this includes stepparents, grandparents and/or any caretakers who can have access to this patient's records and protected health information (PHI):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OUR NOTICE OF PRIVACY PRACTICES ARE INCLUDED IN THIS CLIPBOARD AND ARE ALSO DISPLAYED AT THE RECEPTION DESK. YOU MAY REQUEST TO HAVE A PERSONAL COPY OF OUR NOTICE. Please ask our front desk staff for a copy to keep if you would like one for your records.

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 Notice of Privacy Practices. Your HIV and Hepatitis B test results, if any, may be disclosed to persons and/or under circumstances specified in Wisconsin Statutes 252.15 (5). A listing of those persons and/or circumstances is available upon request.

CONSENT: I (please print your name) _____, 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 (PHI), as described in this form.

Signature: _____ Date: _____

If this consent is signed above by a personal representative, parent or guardian on behalf of the patient, please complete the following:

Personal Representative's Name (please print): _____

Relationship to Patient (please print): _____

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. Revocations 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.