KENDRA S. SCHAEFER, DMD, LLC
PROSTHODONTICS OF MADISON

HIPAA OMNIBUS RULE AND WISCONSIN CONSENT FOR HIPAA PRIVACY
ACKNOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

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 uses and disclosures of your protected health information (PHI) and of other important matters about your protected health information.

In signing this HIPAA Patient Acknowledgement and 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./Ms. with 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, your patient records and protected health information (PHI):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OUR NOTICE OF PRIVACY PRACTICES ARE INCLUDED IN THIS CLIPBOARD, DISPLAYED AT THE DESK AND ARE AVAILABLE FOR REVIEW AND PRINT ON OUR WEBSITE: WWW.PROSTHODONTICSOFMADISON.COM.

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. HIV and/or Hepatitis B test results, if any, may be disclosed to persons and/or under circumstances specified in Wisconsin Statutes 252.15 (5).

CONSENT: I, (print your name) _____ have been informed of this office's Notice of Privacy Practices. I understand that by signing this form, I am confirming my written permission for the disclosure of my protected health information (PHI).

Signature _____ Date _____

Parent/Guardian/Personal Representative:
Signature _____ Date _____