HIPAA Disclosure Form:

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION-HIPAA

SECTION A: PATIENT GIVING CONSENT
Patient First Name

_____

Patient Middle Name

_____

Patient Last Name

_____

Patient Billing Address

_____

_____

_____

Best Contact Number

_____

Social Security Number

_____

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. A copy of our Notice accompanies this Consent. 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. Those changes may apply to any of your protected health information that we maintain.

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 on this form. 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.

WISCONSIN ADDENDUM TO NOTICE OF PRIVACY PRACTICES

This Addendum to the Notice of Privacy Practices sets forth Wisconsin Privacy Requirements that are in addition to this is our Notice of Privacy Practices (Federal HIPAA Law). Please review carefully. The Privacy of Your Health Information is Important to Us.

We are required by Wisconsin law to maintain the privacy of your health information.

Uses and Disclosures of Health Information

Healthcare Operations:
Under Wisconsin law, we must have your written permission before we may use and disclose your health information in connection with healthcare operations other than the management of our medical records and certain auditing and review activities by staff committees and review organizations.

To Persons Involved in Your Care:
Under Wisconsin law, we must have your written permission before we may use and disclose your health information, other than limited identifying information to persons involved in your care.

Abuse or Neglect:
Under Wisconsin law, we must have your written permission before we may use and disclose your health information to the appropriate authorities if we believe you are the victim of domestic violence or other crimes. We may report abuse or neglect of a child or vulnerable adult as allowed by Wisconsin law.

Patient Rights
Restrictions: While we are allowed to determine whether we agree o your request to restrict our use and disclosure of your protected health information, Wisconsin law requires we honor certain restriction requests by private pay patients relating to research or the release of information to government agencies.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Contact officer:
Jenny Nithalangsy
info@rdhcommunications.org
#262-510-9104

SECTION C: THE USES AND DISCLOSURES BEING AUTHORIZED
Our Use of Dental Health Information:
By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and healthcare operations as set forth in our Privacy Practice Notice.

Persons Involved in Care:
By signing this form, you will consent to our use and disclosure of your dental care records to the following persons, including those involved in the payment of your care. We may also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing those involved in your care or payment for that care.

Please list the person(s) you would like involved in your care:
_____

_____
_____

Privacy Practice Policy: A copy will be emailed to the patient / legal guardian

SIGNATURE FOR CONSENT
I, the patient/and or legal guardian have had the full opportunity to read and consider the content 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 healthcare operations.

Legal Guardian Signature and/or patient signature

_____

Date _____