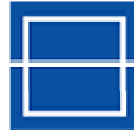
Dr. Gregory Lamansky DDS
5305 Rib Mountain Drive
Wausau, WI 54401



ASSOCIATED
ORTHODONTISTS

WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written 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 dental care records to carry out treatment, payment activities, and health care operations.

SECTION A: Individual giving consent

Name: «resparty_full_name»

Patient Name: (if different from above) «patient_full_name»

Address: «resparty_address_1» «resparty_city»,«resparty_state» «resparty_zip»

Telephone: «resparty_phone»

TO THE INDIVIDUAL: Please read the following and complete the information requested.

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.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice 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, and of other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely, before signing this consent.

SECTION B: The uses and disclosures of 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 health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental records to the following persons, including those involved in your care or payment for that care, such as family dentist, medical doctor, etc.

«dentist_full_name» ____

We may use professional judgment and our experience with common practice to make reasonable inferences 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.

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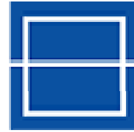

ASSOCIATED ORTHODONTISTS

Our disclosure of Medical information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION C: Revocation:

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 the Contact Person listed below. Revocation 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 continue treating you if you revoke this consent.

Contact: Dr. Gregory Lamansky, DDS

5305 Rib Mt Drive
Wausau, WI 54401
Phone: 715-355-7800
Fax: 715-355-3095

Associated Orthodontists of Wausau

1030 Oak Ridge Drive
Eau Claire, WI 54701
Phone: 715-836-0178
Fax: 715-836-0178

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, «resparty_full_name», have received a copy of this office's Notice of Privacy Practices.

Please print name of patient if different than above.

Signature   Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____Communications barriers prohibited obtaining the acknowledgement.

____An emergency situation prevented us from obtaining acknowledgement.

____Other (Please Specify)