ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that Leipnitz Dental Clinic, S.C.'s Notice of Privacy Practices for protected health information has been made available to me as required under both Federal and Wisconsin law.

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 Practice Notice: 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 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 is available from our office at anytime it is requested.

Uses and Disclosures Being Authorized

Our Use of Medical Information: By signing this form, you will consent to our use of your patient health care records, mental health treatment records, and HIV test information to carry out treatment, payment activities, and health care operations as set forth in our Notice of Privacy Practices.

Other Persons (Spouse, Friend, Son, Daughter, Agency, etc.) Involved in Care: By checking the circle below, you indicate your consent to:

○ Our disclosure of your health care records, mental health treatment records, HIV test results for disaster relief purposes as permitted by law, and to the following named persons, including those involved in your care or payment for that care:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Date: __________________________

Name of Patient:____

Print Name:____

Signature of Patient/Personal
Representative:____