

**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.

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 Privacy Officer at our office. 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 continue treating you if you revoke this Consent.

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 signing this form 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): _____

Signature of Patient/Personal Representative: _____