# Chippewa Valley Dental Health and Accelerated Orthodontics
# Dr. Mark Olson
# Wisconsin Consent Form

Purpose: This form is to obtain an individual's written permission under Wisconsin law for our use and disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care.

**Section A: Individual giving consent**

Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

To the Individual: Please read the following and complete the information requested
Effect to 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 Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent form.

**Section B: The uses and disclosure being authorized**
Our Use of Medical Information: By signing this form, you will consent to our use of your patient health care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.
Facility Directory and Persons Involved in Care: By signing this form, you consent to our listing of your general condition in our facility directories, our disclosure of your patient health care records for disaster relief purposes as permitted by law, and to the following persons, including those involved in your care or payment for that care.

Please list the individuals you would like us to discuss your health care records and/or account information with:

_____ _____

We may use our 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 prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

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 Privacy Practices Notice.

**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 Officer 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 to continue treating you if you revoke this consent.

Contact Officer: Andrew M. Olson Address: 2914 London Road, Eau Claire, WI 54701
Telephone: (715-832-3832) Fax: (715-832-3831)

Individual's Signature
I have had full opportunity to read and consider the contents of this consent. I understand that by signing this form, I am (a) confirming my written permission for the disclosure of my protected health information, as described in this form and (b) acknowledging that I have received a copy of this office's Notice of Privacy Practices.

_____
(Signature) (Date)
If this consent is signed by a personal representative on behalf of the individual, complete the following:

_____
(Personal Representative's Name) (Relationship to Individual)