HIPAA PRIVACY

Consent for Use and Disclosure of Health Information

Hulse Dental

1840 East Main Street
Onalaska, WI 54650
Ph: 608-783-1306

I, _____(Patient's Name) understand that as part of my health care, ***Hulse Dental*** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

~a basis for planning my care and treatment;
~a means of communication among the health professionals who may contribute to my health care;
~a source of information for applying my diagnosis and surgical information to my bill;
~a means by which a third-party payor(insurance) can verify that services billed were actually provided;
~a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

If requested, I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review ***Hulse Dental's*** notice prior to signing this authorization. I authorize the disclosure of my Protected Health information as specified below for the purposes and to the parties designated by me.

Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations

I understand that:

~I have the right to review ***Hulse Dental's*** Notice of Information practices prior to signing this consent;

~That ***Hulse Dental*** reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address we have been provided if requested;

~I have the right to object to the use of my health information for directory purposes I may revoke this consent in writing at any time

~I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and the ***Hulse Dental*** is not required by law to agree to the restrictions requested.

Signature of Patient or Legal Representative _____

Printed Name of Patient or Legal Representative_____

Date:_____