Bardill Dental Associates, S.C.
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name ________________________ Date of Birth ____________

Address ________________________ Apt/Unit ____________

City ________________________ State ____________ Zip Code ____________

Home Phone ________________________ Preferred Contact ____________

SECTION B: TO THE PATIENT

Please read the following statements carefully.

- **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information in order to carry out treatment, payment, activities (including reminder calls), and healthcare operation.
- **Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment, activities, healthcare operation, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

  We reserve te right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. The changes may apply to any of your protected health information that we maintain.

  You may obtain a copy of our Notice of Privacy Practices, inmccluding revisions of our Notice at any time by contacting our office manager, Suzie, at 715-386-5888 during office hours.
- **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 contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent prior to receiving your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SECTION C: PATIENT CONSENT

I, ________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient Signature ________________________ Date ____________

If this consent is signed by a personal representative on behalf of the patient, please complete the following information:

Personal Representative's Name ________________________ Date ____________

Relationship to Patient ________________________

You are entitled to a copy of this consent after signing it.