Patient Name_____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text.

_____ _____

Signature (Responsible Party, if under 18) Date

PRIVACY PRACTICES

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare 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. We reserve the 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. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: HEATHER M. KALMUCK, DDS, SC
Telephone: (920) 459-8467 Fax: (920) 459-9886
Address: 2905 S. 12th St. Sheboygan, WI 53081

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

_____ _____

Patient's Signature (Responsible Party, if under 18) Date

PATIENT/RELATIVE HIPAA CONSENT:

I understand that by signing this Consent form, I am giving my consent to **Heather M. Kalmuck DDS, SC** to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member(s):

Name:_____ Relationship: _____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

_____ _____

Patient's Signature (Legal Guardian, if under 18) Date