PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

Existing Wisconsin Law requires us to obtain written consent prior to disclosing any of your information except for our disclosures in connections with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment fees; a third party payer's examination of our records; a court order as part of criminal investigation; post mortem identification; a licensure investigation; or child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGEMENT AND CONSENT

PLEASE SIGN THIS FORM BELOW TO ACKNOWLEDGE THAT YOU HAVE TODAY READ A COPY OF OUR NOTICE OF PRIVACY PRACTICES (COPY PROVIDED UPON REQUEST) AND THAT YOU CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

Signature_____

Print Name_____**Date**_____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____   _____
        (PLEASE PRINT NAME)   RELATIONSHIP

_____   _____
        (PLEASE PRINT NAME)   RELATIONSHIP

_____   _____
        (PLEASE PRINT NAME)   RELATIONSHIP