NORTHSTAR DENTAL GROUP
WISCONSIN CONSENT
(Wisconsin)

HIPPA

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment & authorization.
In refusing we *may not be allowed* to process your insurance claims.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT INFORMATION OR RADIOGRAPHS BE SENT TO ANOTHER DOCTOR OR FACILITIES IN THE FUTURE.

_____ Please ***print*** name of Patient

_____ Please ***sign*** for Patient/Guardian

_____ Patient Legal Representative/Guardian

_____ Relationship of Legal Representative/Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, DISCUSS TREATMENT, HEALTH and/or BILLING INFORMATION VIA:

_____ Home Phone _____ Work Phone _____ Cell Phone

_____ Text Message _____ Email _____ Any of these contact points