Draver Dental, LLC
Acknowledgement and Consent for use and Disclosure of Health Information

*** You May Refuse to Sign This Acknowledgment ***

I, _____, have received a copy of this office's Notice of Privacy Practices. 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 healthcare operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Representative's Name:_____Relationship to Patient_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Hannah G. Draver, DDS
Telephone: 414.962.0389
E-mail: Team@DraverDental.com
Address: 3970 N. Oakland Avenue, Suite 403 Shorewood, WI 53211

Disclosure to Family: I consent to allow you to disclose my health information to a family member or relative:

Insurance benefit information may be released to or discussed with my: (check and initial)
Spouse □ _____ Parent(s) □ _____ Other: _____
Appointment information may be released to or discussed with my:
Spouse □ _____ Parent(s) □ _____ Other: _____
Diagnosis/treatment information may be released to or discussed with my:
Spouse □ _____ Parent(s) □ _____ Other: _____

We may use professional judgment and common practice experience to make reasonable inferences of your best interest to allow a person acting on your behalf to pick up medical supplies, X-rays, or similar forms of protected health information.

Appointment Reminders: I consent to allow you to use or disclose my health information to provide me with appointment reminders (such as voicemail, messages, postcards, or letters).I also consent to allow you to include a reminder to premedicate (if applicable) for my appointments.

(check and initial) Yes □ _____ No □ _____

Electronic Communications: I agree that the dental practice may communicate with me electronically at the email address below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice with any updates to my email address.I can withdraw my consent to electronic communications by calling: (414)962-0389.
Email Address:_____

Communication Preference:
I prefer to be contacted via: Email □ _____ Cell □ _____ Other: _____

For Office Use Only

Include completed Consent in the patient's chart.

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)