DENTAL ASSOCIATES of Baraboo

Consent for Use and Disclosure of Patient Information

Name: _____ DOB: _____

Please read the Following Statements Carefully

By signing this form, you will consent to our use and disclosure of your protected dental information to carry out treatment and payment activities.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and operations, including the uses and disclosures of your protected health/dental information. A copy of our notice is available on our website and by request in our office.

You have the right to revoke this consent at any time by submitting written notice of your revocation to our office. Dental Associates of Baraboo, 880 14th Street, PO Box 558, Baraboo, WI 53913.

Signature: I have had an opportunity to read and consider the content of this consent form. I understand that by signing this consent form I am giving my consent to disclose my dental treatment and health information to the following person(s).

Please list any persons you wish to have access to your account.

_____

_____

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Signature_____ **Date**_____