WISCONSIN

ADDENDUM TO NOTICE OF PRIVACY PRACTICES

This Addendum To The Notice Of Privacy Practices Sets Forth Wisconsin Privacy Requirements That Are In Addition To Those In Our Notice Of Privacy Practices. Please Review It Carefully.

The Privacy Of Your Health Information Is Important To Us.

We are required by Wisconsin law to maintain the privacy of your health information.

Uses and Disclosures of Health Information

Healthcare Operations: Under Wisconsin law, we must have your written permission before we may use and disclose your health information in connection with healthcare operations other than management of our medical records and certain auditing and review activities by staff committees and review organizations.

To Your Family and Friends and Persons Involved in Your Care: Under Wisconsin law we must have your written permission before we may disclose your health information, other than limited identifying information, to your family, friends, or other persons involved in your care.

Abuse or Neglect: Under Wisconsin law, we must have your written permission before we may disclose your health information to the appropriate authorities if we believe you are the victim of domestic violence or other crimes. We may report child abuse and the abuse or neglect of a vulnerable adult as allowed by Wisconsin law.

Patient Rights

Restriction: While we are allowed to determine whether we agree to your request to restrict our use and disclosure of your protected health information. Wisconsin law requires that we honor certain restriction requests by private pay patients relating to research or the release of information to government agencies.

Contact Officer: Judy Telephone: (715) 424-2301

E-mail: thedentalsuite@solarus.net Fax: (715) 424-2309

Address: 2301 Chestnut Street
P.O. Box 1177
Wisconsin Rapids, WI 54495-1177

WISCONSIN CONSENT FORM

The Dental Suite LLC
M. Elizabeth Doolittle DDS
P.O. Box 1177
2301 Chestnut Street
Wisconsin Rapids, WI 54495-1177

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operation.

SECTION A: Individual getting consent

Patient's Full Name: _____

Address: (with city and zip code) _____

Telephone: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practice Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care 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 dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and complete before signing this consent.

SECTION B: The uses and disclosures being authorized

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practice Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care of payment for that care. Please list the person(s) you would like involved in your care of payment for that care.

_____ _____

_____ _____

_____ _____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practice Notice, and to our disclosure of your dental records for disaster relief purposes as permitted by law.

SECTION C: Revocation

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Office: The Dental Suite LLC
Dr. M. Elizabeth Doolittle

Telephone: (715) 424-2301

Address: 2301 Chestnut Street
P.O. Box 1177
Wisconsin Rapids, WI 54495-1177

INDIVIDUAL'S SIGNATURE:

I, _____ have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent on behalf of the individual, please complete the following:

Personal Representative/Parent Name: _____

Relationship to Individual: _____ Date: _____