HIPAA

ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment and payment activities as set forth in our Notice of Privacy Practices.

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 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 Notice is available from our office at any time it is requested.

I acknowledge that Clearwater Dental SC Notice of Privacy Practices has been made available to me as required under Federal and Wisconsin law. This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Other Persons (Spouse, Friend, Son, Daughter, Agency, etc,) Involved in Care: By checking the box below, you indicate your consent to:

☐ Our disclosure of your health care records to the following named below, including those involved in your care or payment for that care. Name: _____

Print Name: _____ Signature: _____

Date: _____

Updated: 2/16/2026