



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 Practices Notice, and to our disclosure of your dental care 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: Roger J. Gollon, DDS
Telephone: 715-341-7665
Address: 1570 American Drive, Plover, WI 54467

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, complete the following:

Personal Representative's/Parent Name: _____

Relationship to Individual: _____

P&P § 1(e)
Version 2.3 (13/01/02)
Authority: 45 C.F.R. § 164.506(a)
File Name: W1CONSNT.DOC

© 2002 Michael Best & Friedrich LLC