ELIZABETH V. WAWRZEWSKI DDS LLC
FAMILY DENTISTRY
3455 W. 13TH ST. N
WICHITA, KANSAS 67203
316.943.2341

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HIPPA CONSENT

PURPOSE OF CONSENT: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decided whether you want to sign this consent form. Our Notice provides a description of our treatment, payment activities and the healthcare operations, of the uses and disclosures we may make of your protected Health Information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our practices, we will issue a revised issue of the Notice of Privacy Practices, which will contain any changes.

You may obtain a copy of our Notice of Privacy Practices, any time by contacting our office.

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PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby allow Dr. Elizabeth V. Wawrzewski to disclose in writing or verbally my medical/dental information to the following people, because they are involved with my health care or payments:

- SELF_____
- SPOUSE_____
- FAMILY MEMBER_____
- FRIEND_____
- OTHER_____

Patient Name: _____

Date: _____

Signature of Patient or Responsible Party: _____