Viroqua Dental Center, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND WISCONSIN CONSENT FORM

As required by the Privacy regualtions, I here by acknowledge that I have received a current copy of this practice's Notice of Privacy Practices, revison date Feb. 16th 2026 I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effectice for all protected health information that it maintains. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

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

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

We may use professional judgement and our experience with common practice to make reasonable inferences of our best interest in allowing a person acting on your behalf to pick up filled perscriptions, medical supplies, x-rays or other similar forms of protected health information.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at anytime by giving written notice of revocation to the contact office listed below. Revocation of this consent will not affect any action we took in relaince on this authorization before we received your written notice of revocation.

Contact office: Viroqua Denal Center, LLC Contact Officer: Robert Klum

Telephone: (608)637-2655 Address: 1225 Favor Drive, Viroqua, WI 54665

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

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.

Patient's Name:_____ Date:_____

Signature:_____

If signed by personal representative list name and relationship to individual:

_____

(office use only)

Signed form received by:_____ Date:_____

Good faith effort to obtain receipt: (describe)_____