STEVEN M. AMATO, D.D.S, M.S., S.C.

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 CAREFULY.

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 case.

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.

Patient Signature _____

Guardian Signature _____

STEVEN M. AMATO, D.D.S., M.S., S.C.
MANITOWOC, WI

PATIENT ACKNOWLEDGMENT OF PRIVACY NOTICE

patient name

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 on behalf of the individual, complete the following:

Personal Representative's Name:_____

Relationship to Individual:_____

Dependents:

_____

_____

_____

_____

_____