WILKE ORTHODONTICS LTD

PERSONALIZED ORTHODONTIC CARE

DR. KEVIN J. WILKE, DDS, MS

Acknowledge of
Receipt of Notice of Privacy Practices

Patient Name:______________________________ Date of Visit:____________

My signature on this form acknowledges that I have received a copy of Wilke Orthodontics, Ltd.'s Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which health information may be used or disclosed by Wilke Orthodontics, Ltd., and of my rights with respect to my health information.

By signing this form, I consent to Wilke Orthodontics' use of my patient health information to carry out treatment, payment activities, and health care operations as set forth in their Notice of Privacy Practices.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information

______________________________ ______________________________

Patient's Signature Date

______________________________ ______________________________

Signature of Patient's Representative Date
(*if patient is a minor or unable to sign*)

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I hereby give consent to Wilke Orthodontics, Ltd., to give my patient health information to:

______________________________ ______________________________

Print Name and Relationship to Patient Date

______________________________ ______________________________

Print Name and Relationship to Patient Date

This consent is effective until revoked by me. I may revoke this consent at any time by giving written notice of revocation to Wilke Orthodontics, Ltd. Revocation of this consent will not affect any action Wilke Orthodontics, Ltd., took in reliance on this authorization before receiving written noticed of revocation. Treatment may be declined or discontinued if consent is revoked.

☐ *Patient/representative was provided with a copy of the Notice of Privacy Practices, but declined to sign form.*

Member
American Association of
Orthodontists

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