East Tennessee Ear, Nose, Throat, Allergy, Head & Neck Specialists, PC

Consent to the Use and Disclosure of Health Information

Name_____ DOB_____

Our Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

I authorize my medical information to be discussed/disclosed to:

☐ **Family member or friend_____** ☐ **Physician _____**
FULL NAME **FULL NAME**

☐ **Other_____**
FULL NAME

Detailed messages regarding test results and appointment reminders can be left on answering machine or voicemail:

☐ **Yes** **Please list Phone #_____** ☐ **No**

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for East Tennessee Ear, Nose, Throat, Allergy, Head & Neck Specialists, PC.

_____ _____
Signature of Patient or Legal Representative Date