

Ear, Nose & Throat Consultants of Nevada

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your protected health information will be used by Ear, Nose & Throat Consultants of Nevada or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

You may request a restriction on the use or disclosure of your protected health information. Ear, Nose & Throat Consultants of Nevada may or may not agree to restrict the use or disclosure of your protected health information. If Ear, Nose & Throat Consultants of Nevada agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCACTION OF CONSENT

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES

Ear, Nose & Throat Consultants of Nevada reserves the right to modify the privacy practices outlines in the notice.

AUTHORIZED PERSONS TO RECEIVE DISCLOSED INFORMATION:

Name: _____
Person Who is authorized to Receive Records

Relationship to patient: _____

Name: _____
Person Who is authorized to Receive Records

Relationship to patient: _____

Signature

I have reviewed this consent form and give my permission to Ear, Nose & Throat Consultants of Nevada to use and disclose my health information in accordance with it.

Name of Patient (Print or Type)

Date

Signature of Patient / Patient Representative / Relationship to Patient