

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 ALPINE EAR, NOSE & THROAT, P.C. 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 of Disclosure of Your Information.

You may request a restriction on the use or disclosure of your protected health information.

ALPINE EAR, NOSE & THROAT, P.C. may or may not agree to restrict the use or disclosure of your protected health information.

If ALPINE EAR, NOSE & THROAT, P.C. 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.

Revocation 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

ALPINE EAR, NOSE & THROAT, P.C. reserves the right to modify the privacy practices outlined in this notice.

I have reviewed the consent form and give my permission to ALPINE EAR, NOSE & THROAT P.C. to use and disclose my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient or Patient Representative

Date

Relationship of Patient Representative to Patient

PRIVACY POLICY

I acknowledge that I have received a copy of ALPINE, EAR NOSE & THROAT, P.C.'S Privacy Policy.

Signature of Patient or Patient Representative

Date

The following family members or representatives have my authorization to obtain or relay medical information with ALPINE EAR, NOSE & THROAT.

Name

Relationship

Name

Relationship

Name

Relationship