

AUGUSTA



ear • nose • throat

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Augusta ENT, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with a Notice of Privacy Policies that provides a complete description of information uses and disclosures in addition to my rights.

I understand that Augusta ENT, PC is not required to agree to any restrictions requested by me. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Augusta ENT, PC reserves any right to change their notice in accordance with Section 164.520 of the Code of Federal Regulations. Should Augusta ENT, PC change their notice an updated copy will be available upon my next visit to the practice and/or I may request a copy be sent to my address. I also may visit the office at any time to obtain a current copy of the practice's Notice.

I wish to have the following restrictions to the use or disclosure of my health information:

Three horizontal lines for writing restrictions.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

*** I fully understand and (circle one) [accept / decline] the terms of this consent. ***

Signature lines for Patient's Signature, Date, Practice Representative Witness, and Date.

I request that Augusta ENT, PC please contact me by phone at _____ with appointment reminders and furthermore give my permission to leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that no other information will be provided in granting permission to leave the date and time and I further understand that I may revoke this authorization at any time in writing to Augusta ENT, PC.

Initial _____ Date _____

FOR OFFICE USE ONLY

- [] Consent received by _____ on _____
[] Consent refused by patient, and treatment refused as permitted.
[] Notice provided to patient. Consent form not signed due to: _____

Action to be taken: _____