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Albany ENT

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Health Insurance Portability and Accountability Act

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I hereby give my consent for Albany Ear, Nose, Throat, Sinus and Allergy, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Albany Ear, Nose, Throat, Sinus and Allergy's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)
- I have the right to review the Notice of Privacy Practices prior to signing this consent. Albany Ear, Nose, Throat, Sinus and Allergy reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained by forwarding a written request to Albany Ear, Nose, Throat, Sinus and Allergy's Privacy Officer at 650 Pointe North Blvd, Albany, GA 31721.
- I have the right to request that Albany Ear, Nose, Throat, Sinus and Allergy restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
- I have the right to inspect and copy PHI.
- I have the right to request an amendment to PHI.
- I have the right to request restrictions on certain uses and disclosures of PHI, including requesting that a health plan not be informed of treatment for which I, the patient, paid entirely out of pocket.
- I have the right to prohibit the sale of my PHI, its use for marketing purposes, or participation in research.
- I have the right to receive an accounting of disclosures of PHI, this is a list of those third parties who have been given access to the patient's PHI.
- I have the right to complain about a HIPAA privacy violation
- With this consent, Albany Ear, Nose, Throat, Sinus and Allergy, may call, hand directly to patient, mail, email my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, letters and patient statements, insurance items and any calls pertaining to my clinical care, including laboratory.
- By signing this form, I am consenting to Albany Ear, Nose, Throat, Sinus and Allergy's use and disclosure of my PHI to carry out TPO.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Albany Ear, Nose, Throat, Sinus and Allergy may decline to provide treatment to me.
- **I AUTHORIZE ALBANY ENT TO OBTAIN MY MEDICATION HISTORY FROM ALL OF MY PHARMACY PROVIDERS.**

Please Print *Patient* (adult or child) Name _____

Guarantor or Patient Signature and Date _____

Relationship to Patient_____