

PATIENT HIPPA AWARENESS

With my permission, ENT Faculty Practice, LLP may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Please refer to ENT Faculty Practice, LLP Notice of Privacy Practices for more complete description of such uses and disclosures.

It is my responsibility to review the Notice of Privacy Practices prior to signing this consent. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of ENT Faculty Practice, LLP, may call my home or other designated locations and leave a message on my voice mail or in person in reference to any item that assists the practice in carrying out TPO , such as appointments, reminder cards, and patient statements. I have the right to request the ENT Faculty Practice, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does it is bound to this agreement.

By signing this, I am allowing ENT Faculty Practice, LLP to use and disclose my PHI for 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.

SIGNATURE OF PATIENT,
PARENT OR LEGAL GUARDIAN

PRINT NAME OF PATIENT
PARENT OR LEGAL GUARDIAN

PATIENT'S NAME: _____

DATE: _____