COMMUNITY ENT & ALLERGY, PLLC.

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Physician for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Community ENT & Allergy. I understand that any analysis, diagnosis or treatment of me by physician may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Physician is not required to agree to the restrictions that I may request. However, if physician agrees to a restriction that I request, the restriction is binding on physician. I have the right to revoke this consent, in writing, at any time, except to the extent that physician has already taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of a summary of the Notice of Privacy Practices of Community ENT & Allergy and understand that I have a right to view or be provided a complete copy of the Notice of Privacy Practices prior to signing this document at my request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of physician. The Notice of Privacy Practices for physician is also posted in the waiting room at 4950 Norton Healthcare Blvd. This Notice of Privacy Practices also describes my rights and duties of the physician with respect to my protected health information.

Physician reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Community ENT & Allergy and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____	_____
Signature Patient/Parent/Guardian	**Printed Name of Signer**	**Date**

If patient is a minor child: Please list any individuals that may be bringing your child to their appointments in your absence: MUST BE LEGIBLE!!!

_____	_____
Name	Relation to patient
_____	_____
Name	Relation to patient
_____	_____
Name	Relation to patient
_____	_____
Name	Relation to patient