



Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Practitioner” refers to Northwest Florida ENT.

I consent to the use or disclosure of my protected health information by Practitioner 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 Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand 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. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has 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 the Notice of Privacy Practices of Practitioner and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. 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 Practitioner. The Notice of Privacy Practices for Practitioner is also posted in the waiting room at [insert address of practice]. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner 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 Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative’s Authority