Ear Nose & Throat
OF SPRINGFIELD
Quality care, close to home.

Ear Nose and Throat of Springfield

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for ENT of Springfield to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by ENT of Springfield describes such issues and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ENT of Springfield reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Manager (privacy officer) of ENT of Springfield, 435 S. Burnett Rd, Springfield, OH 45505.

With this consent, ENT of Springfield may call 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, insurance items and any calls pertaining to my clinical care, including laboratory test results.

With this consent, ENT of Springfield may mail to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, ENT of Springfield may e-mail to me any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ENT of Springfield restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree with my requested restrictions, but if it does, it is bound by that agreement.

By signing this form, I am giving ENT of Springfield my consent to use and disclose 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 extent, or later revoke it, ENT of Springfield may decline to provide treatment to me.

Signature Date Relationship

Print Patient Name Print name of legal guardian (if applicable)