INDEPENDENCE EAR, NOSE, & THROAT

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA CONSENT FORM

04/2022

Patient Name: _____ Date of Birth: _____

This consent form allows Independence Ear, Nose & Throat to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Independence Ear, Nose & Throat has provided me with a Notice of Privacy Practices, with more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Independence Ear, Nose & Throat.

_____ Initial I hereby authorize that Independence Ear, Nose & Throat may text me or leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ Initial I hereby authorize that Independence Ear, Nose & Throat may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ Initial I hereby authorize that Independence Ear, Nose & Throat may disclose my personal health information to the person who I have listed as my emergency contact.

_____ Initial I hereby authorize that Independence Ear, Nose & Throat may disclose my personal health information, including release of printed documents and pick-up prescriptions, to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Independence Ear, Nose & Throat services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Independence Ear, Nose & Throat may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Independence Ear, Nose & Throat is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Independence Ear, Nose & Throat may refuse me services if I refuse to sign this consent.
By my signature below, I affirm the above information.

Signature of Patient _____ **Date:** _____

Signature of Parent (if minor) / Authorized Representative _____ **Date:** _____