SACRAMENTO
EAR | NOSE | THROAT
FACIAL PLASTIC SURGERY

Privacy Consent and Authorization for Use/Disclosure Form

Sacramento Ear, Nose, & Throat Surgical and Medical Group, Inc. and S.E.N.T. Hearing Aid Center (collectively "SacENT") recognizes and respects the fact that all patients have the right to inspect and obtain a copy of their own containing their Protected Health Information ("PHI"). I understand I have the right to review SacENT's Notice of Privacy Practices prior to signing this form. SacENT reserves the right to revise its Notice of Privacy Practices at any time.

Consent:

With this consent, SacENT may use and disclose any PHI about myself (or my child) to carry out treatment, payment (including collection of payments), and healthcare operations. Please refer to SacENT's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, this office may mail to my home or other designated location or leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or other healthcare operations, such as appointment reminders, insurance items, payment items, and any other information regarding my (or my child's) healthcare as long as they are marked "Personal and Confidential". With my consent, SacENT may e-mail any information regarding my (or my child's) health care, treatment, payment and appointments to me.

I understand I have the right to request that SacENT restricts how it uses and discloses my health care information to carry out treatment and payment. SacENT is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Authorization Use & Disclosure:

❑ I agree
❑ I Object
That SacENT may also disclose, in its professional judgment, my health care information to such person's directly involved with my health care or payment thereof:

❑ And to persons listed below:

Name of Person Phone No. Relationship

_____

_____

_____

I understand that I have the right to revoke my consent or authorization in writing except to the extent that SacENT has already made use or disclosures in reliance upon my prior consent and authorization. If I do not sign this consent, SacENT may decline to provide treatment to my child or me.

❑ I have read and received a copy of the Notification Privacy Practices.

_____ _____
Print Patient Name Date of Birth

_____ _____
Signature of Patient or Legal Guardian Date