

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Advanced Otolaryngology** or disclosed to others for the purpose of treatment, obtaining payment or supporting the day to day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information.

You may request a restriction on the use or disclosure of your protected health information.

Advanced Otolaryngology may or may not agree to restrict the use or disclosure of your protected health information.

If **Advanced Otolaryngology** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed-upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Advanced Otolaryngology reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and give my permission to **Advanced Otolaryngology** to use and disclose my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient