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Allergy Ear Nose & Throat INSTITUTE
EXCELLENCE SINCE 1992
"To God be the Glory"

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Effective: September 22, 2013

I understand that as part of my health and medical care the Allergy Ear Nose & Throat (AENTI) originated and maintains medical and health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment for my bill
- A means for a third-party payer to verify that services were billed as actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future.

I understand and have been provided with a **PATIENT PRIVACY NOTICE (PPN)** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that AENTI reserves the right to change their notice and practices, but prior to implementation will notify patients by posting the new PPN in the AENTI lobby, on the AENTI website, www.allergyENTinstitute.com, and an updated Consent Form will be given to be signed at your next scheduled appointment. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or discloses to carry out treatment, payment, or healthcare operations and that AENTI is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent the organization has already taken action I reliance thereon.

This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

By Oklahoma law we are required to notify you…**that the information authorized for release may include records which may indicate presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

By signing this form I also agree to allow AENTI to contact me by any phone number I have provided to include home, cellular, or work, or message contact for the purpose of reminder calls, collection services and/or medical information. I also authorize AENTI to leave voicemail messages on my home and/or cellular phone numbers and send text message appointment reminders.

Information may be released to the following individuals or organizations for the indicated purpose:

Name of Person or Organization: Relationship: Purpose for Release:

_____

_____

_____

I request the following restrictions to the use and/or disclosure of my health information:

_____

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date Notice Effective

This form is being provided to meet HIPAA Requirements