Bluegrass Ear, Nose & Throat Clinic, PSC
General Otolaryngology • Allergy & Sinus Disease • Audiology & Hearing Aids
Clark Clinic B • 225 Hospital Drive, Suite #265 • Winchester • Kentucky • 40391
☎: 859-745-1010 / 866-966-7468 • Fax: 859-745-0080 • www.bluegrassentclinic.com

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how **Bluegrass Ear, Nose & Throat Clinic, PSC (BENTC)** may use and disclose protected health information (PHI) about you to carry out treatment, payment and healthcare operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this consent. **BENTC** reserves the right to revise its Notice of Privacy Practices at any time. If we change our Notice, you may obtain a revised copy by contacting our office. **BENTC** provides the Notice of Privacy Practices to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I consent to **BENTC**'s use and disclosure of protected health information about me for treatment, payment and health care operations. I have the right to revoke this consent, in writing, signed by me. However, such a revocation shall not affect any disclosures **BGENTC** has already made in reliance on my prior consent. If I do not sign this consent, **BENTC** may decline to provide treatment to me or to continue treating me if I revoke this Consent.

I, the patient/guardian, understand that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that I have the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the uses of my information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- I may revoke this Consent in writing at any time and all future disclosures will then cease.

With this consent, **BENTC** 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 call pertaining to my clinical care, including laboratory results among others.

With this consent, **BENTC** may mail to my home or other alternative location any items that assist the Practice in carrying out TPO, such as patient statements, collection letters and any other correspondence or related material.

With this consent, **BENTC** may e-mail to my home or other alternative location any items that assist the Practice in carrying out TPO, such as appointment reminder e-mail messages and patient statements.

However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **BENTC**'s use and disclosure of my PHI to carry out TPO.

✘____ ______/______/20_____

Signature: ❒ Self ❒ Mother ❒ Father ❒ Guardian **Date Signed**

✘____

Name of Patient or Guardian/Responsible Party (PRINT)