



## Privacy Consent and Authorization for Use/Disclosure Form

Sacramento Ear, Nose & Throat Surgical and Medical Group, Inc., and SENT 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 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 health care 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 health care operations, such as appointment reminders, insurance items, payment items, and any call pertaining to my clinical care, including laboratory results and information, among others, and any other information regarding my (or my child's) health care as long as they are marked "Personal and Confidential." With my consent, SacENT may email 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  or Object  that SacENT may also disclose, in its professional judgment, my health care information to such persons directly involved with my health care or payment thereof:

to a family member, other relative, or a close personal friend;

or only

Name of Person                      Phone Number                      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

***This document must be signed in the office.***