AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I authorize the use and disclosure of my protected health information by physicians and/or staff of Ear, Nose & Throat Associates of Charleston, Inc. (EN&T) for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care and to conduct operations of EN&T.

My "protected health information" means health information including as an example health history, symptoms, examination and test results, diagnoses, and records of treatment and payment for health services pertaining to me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and to present, past or future payment for the provision of health care and identifies me, or there is a reasonable basis to believe that the information may identify me.

I acknowledge that I have received a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures of my health care information relating to my diagnosis and treatment, obtaining payment for services and health care operations of EN&T. I understand that I have the right to review the Notice prior to signing this authorization. I understand that EN&T reserves the right to change its *Notice of Privacy Practices* and that I may obtain a revised Notice if I so request.

I understand that I have the right to request restrictions on how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that neither physicians or staff of EN&T is required to agree to the restrictions requested.

I understand that I may revoke this authorization in writing at any time, except to the extent that EN&T has relied upon it.

(PLEASE PRINT)

X_____ Initial to authorize EN&T to leave a message on your answering machine.

With whom may we discuss your care (family member(s), personal representative, or another

person involved in your care? X____

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X____________________________________ X_______________________

Patient or Personal Representative | Date

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