

EAR, NOSE & THROAT CONSULTANTS OF NEVADA

W.W. Schroeder, M.D., F.A.C.S., F.A.A.P. David Foggia, M.D. Ashley Sikand, M.D., F.A.C.S. Frederick Goll, III, M.D. Larry Yu, M.D. Timothy Tolan, M.D. Jonathan Salinas, M.D. Christine Mirabal, M.D. Daniel Kim, D.O. Erin Ellis, APRN Theresa Walker, APRN-C

PHONE: (702) 792-6700 FAX: (702) 792-7198 <u>www.entc.com</u>

Using and Disclosing Protected Health Information for Involvement in the Individual's Care and Notification Purposes

As per Notice of Privacy practices, Ear, Nose and Throat Consultants of Nevada must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patient's family members, or friends involved in their care.

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. You may request a restriction on the use or disclosure of your protected health information. Ear, Nose & Throat Consultants of Nevada may or may not agree to restrict the use or disclosure of your protected health information. If Ear, Nose & Throat Consultants of Nevada agree to Protected information in violation of an agreed upon 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.

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. Ear, Nose & Throat Consultants of Nevada reserves the right to modify the privacy practices outlined in the Notice.

This document will serve as a written agreement between

and Ear, Nose & Throat Consultants of Nevada as a list of those designated by the patient as having direct involvement with the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include next of kin and/or persons names you will authorize us to release your medical records to. Persons noted below will have to fill Medical release and show proper Identification before receiving records. It will be the patient's responsibility to update as necessary.

Please mail me a copy of my records. (This will be processed upon request by phone or mail.)

Patients Name	Patients Signature	DOB	
Next of Kin/Family Members			
Name:	Relationship	Phone	
Name:	Relationship	Phone	
Northwest Office	Green Valley Office	Southwest Office	
7040 Smoke Ranch Road	3195 St Rose Parkway Suite 210	8840 W Sunset Road Suite A	
Las Vegas, NV 89128	Henderson, NV 89052 (Mailing address)	Las Vegas, NV 89148	



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I authorize for Ear, Nose & Throat to release Medical records to the following Medical Providers.

 Doctors or Facility Name
 Phone #_____Fax #_____

Doctors or Facility Name ______Phone # _____Fax#_____

Per My Permission-Leave Medical Information on my answering machine-

YES	NO
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I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my revocation to Medical Records Department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtain from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: . If I fail to specify a date, **this authorization will expire one (1) year from the**

signature on this form.

	_Date
Signature of Patient	
	_Date
Signature of Guardian or Personal Representative	

Patient number

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