SEVERN RIVER ENT PLASTIC & LASER SURGERY

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

Severn River Ent Plastic & Laser surgery obtains and maintains health information relating to our past, present or future physical or mental condition, provision of health care or payment for health care, referred to as "Protected Health Information." This Protected Health Information may be used or disclosed by Severn River ENT Plastic & Laser Surgery for purposes of treatment, payment or health care operations, including, but not limited to:

- sending information to your referring doctor;
- planning for my care and treatment;
- calling me with appointment reminders and lab results;
- submitting a claim to my insurer or health plan; and
- assessing the quality of care provided to me.

Severn River Ent Plastic & Laser Surgery *Notice of Privacy Practices* contains a more complete description of how my Protected Health Information may be used and disclosed and how I can obtain access to this information I understand that Severn River Ent Plastic & Laser Surgery reserves the right to change its *Notice* and practices and I can request a copy of its current *Notice.*

I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by Severn River Ent Plastic & Laser Surgery. Severn River ENT Plastic & Laser Surgery is not required to agree to my request but if Severn River ENT Plastic & Laser Surgery does agree, the requested restrictions will be binding.

I further understand that, at any time, I may revoke this consent in writing, except to the extent that Severn River ENT Plastic & Laser Surgery has already taken action in reliance on it.

By signing this form below, I consent to Severn River ENT Plastic & Laser Surgery use and disclosure of my Protected health Information for the purpose of treatment, payment and/or health care operations.

_____ _____

Signature of Patient or Legal Representative Witness

_____

Date

If executed by Legal Representative, Please describe relationship to patient:

_____

_____

I acknowledge that I am aware of the HIPAA Privacy Notice of Severn River ENT Plastic & Laser Surgery. A booklet will be given to me only upon request.

_____ _____
Signature of Patient or Legal Representative Witness

_____
Date

If executed by Legal Representative, Please describe relationship to patient:
_____
_____

I, _____, give my permission to share my PHI(Protected Health Information) with _____, my spouse/ significant other (please circle).

_____ _____
Signature of Patient or Legal Representative Witness

_____
Date