HIPAA GENERAL CONSENT

I hereby give my consent for Central Arkansas ENT Clinic, PA to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I have been informed that my Health Care Provider has adopted a complete statement of its privacy practices, which are contained in Central Arkansas ENT Clinic (Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices and have had an opportunity to review them and ask any questions concerning them before signing this HIPAA Consent. I understand that my Health Care Provider has the right to change them at any time without advance notice to me. I can request a copy of my Health Care Provider's latest Notice of Privacy Practices by calling the office, stopping by and picking up a copy, stopping by and reading the Notice that is posted in my Health Care Provider's waiting room, or asking that my name be put on a list to be mailed a copy of any updated Notice of Privacy Practices should my Health Care Provide make changes to the Notice of Privacy Practices.

I understand that I have the right to not give this consent; however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.

I understand that I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request.

I understand that if my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.

I understand that I have the right to revoke my consent; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it.

I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

_____ _____

Patient – Printed Name Patient – Signature

_____

Date

_____

Personal Representative of Patient

Effective 9/9/2013