Diseases of the Ears, Nose and Throat, Inc.

Otologic Surgery ● Head and Neck Surgery ● Endoscopic Sinus Surgery ● Pediatric Surgery
Complete Audiologic Services ● Dizziness

Otolaryngologists
Timothy J. Nash, DO
Timothy P. Drankwalter, DO

Audiologists
Melinda L. Heater, AuD
Audra H. Woods, AuD

HIPAA Form
Health Insurance Portability and Accountability Act

Consent for Purposes of Treatment, Payment and Healthcare Operations

By signing this form, I consent to the use or disclosure of my protected health information by **Diseases of the Ears, Nose and Throat, Inc.** for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct Diseases of the Ears, Nose and Throat Inc. health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Diseases of the Ears, Nose and Throat Inc. has taken action in reliance on my prior consent.

My "protected health information" means any of my written and oral health information, including my demographic data that can be used to identify me, that has been created or received by Diseases of the Ears, Nose and Throat Inc., and that relates to my past, present or future physical or mental health or condition.

I understand that I have a right to review Diseases of the Ears, Nose and Throat Inc. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of our health care operations. The Notice of Privacy Practices also describes my rights and Diseases of the Ears, Nose and Throat Inc. duties with respect to my protected health information. The Notice of Privacy Practices is posted in the lobby at the Diseases of the Ears, Nose and Throat location.

Diseases of the Ears, Nose and Throat Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Diseases of the Ears, Nose and Throat Inc. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations. Diseases of the Ears, Nose and Throat Inc. is not required to agree to the restrictions that I may request, but if it does, it is bound by its agreement.

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I understand that diagnosis or treatment of me by Diseases of the Ears, Nose and Throat Inc. may be conditioned upon my consent as evidenced by my signature on this document.

_____ _____

Responsible Party Date

Patient name if different from Responsible Party _____

(Over)

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HIPAA Form Continued
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Home/ Daytime contact phone number: _____

Do we have permission to call your home? □Yes □No

May we leave a message with other residents? □Yes □No

To whom at your residence may we talk to about your medical treatment?
Name:_____ Relationship:_____
Home#:_____ Cell#:_____ Other phone:_____

Is this person your emergency contact also? □Yes □No If not, please list emergency contact below:
Name:_____ Relationship:_____
Home#:_____ Cell#:_____ Other phone:_____

Do we have your permission to call you at work? □Yes □No
Work phone #:_____
May we leave a message on your work voicemail? □Yes □No
May we leave a message at work requesting only that you return our call? □Yes □No

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If any of the above information changes, it is the Patient / Parent / Legal Guardian responsibility to contact our office.

_____ _____

Responsible Party Date

Patient name if different from Responsible Party _____