Consent for Purposes of Treatment, Payment and Healthcare Operations

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Summary: This consent form must be completed by a patient before the physician sees the patient (with some exceptions). In signing this consent document, the patient is permitting the physician and the physician's practice to use or disclose the patient's protected health information to treat the patient, to ensure that the patient's bills are paid, and to operate the business of the practice.

I consent to the use or disclosure of my protected health information by Colorado Children's Ear, Nose & Throat, P.C. and Dr. Sharon M. Tomaski (CCENT/SMT) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of CCENT/SMT. I understand that diagnosis or treatment of me by CCENT/SMT may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. CCENT/SMT is not required to agree to the restrictions that I may request. However, if CCENT/SMT agrees to a restriction that I request, the restriction is binding on CCENT/SMT.

I have the right to revoke this consent, in writing, at any time, except to the extent that CCENT/SMT has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from 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 identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review CCENT/SMT's Notice of Privacy Practices prior to signing this document. The CCENT/SMT's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the CCENT/SMT. The Notice of Privacy Practices for CCENT/SMT is also available for review at the Office front desk. This Notice of Privacy Practices also describes my rights and the CCENT/SMT's duties with respect to my protected health information.

CCENT/SMT 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority