GREENWICH
EAR, NOSE & THROAT

ALIGN ENT+ Allergy Partner

Patient Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I have been informed by you of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my health information. I have the right to review such Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices occasionally and that I may contact this organization at any time to obtain a current copy of them.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____ **Signature** _____

Date _____ **Relationship to Patient if Signed by Representative** _____

Align ENT + Allergy Partner Practices may release my medical information to:

Name _____ **Relationship to Patient** _____

Name _____ **Relationship to Patient** _____

Name _____ **Relationship to Patient** _____

Name _____ **Relationship to Patient** _____