

ST. JOSEPH'S EAR, NOSE & THROAT CLINIC
CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

PATIENT hereby consents to the use or disclosure of his/her individually identifiable health information ("Protected Health Information") by St. Joseph's Ear, Nose & Throat Clinic in order to carry out treatment, payment, or health care operations. PATIENT should review St. Joseph's Ear, Nose & Throat Clinic's Notice of Privacy Practices for Protected Health Information ("Notice") for a more complete description of the potential uses and disclosures of such information, and PATIENT has the right to review such Notice prior to signing this consent form.

St. Joseph's Ear, Nose & Throat Clinic reserves the right to change the terms of its Notice at any time. If St. Joseph's Ear, Nose & Throat Clinic does change the terms of its Notice, PATIENT may obtain a copy of the revised Notice by calling St. Joseph's Ear, Nose & Throat Clinic at 208-777-1320.

PATIENT retains the right to request that St. Joseph's Ear, Nose & Throat Clinic further restrict how PATIENT'S protected health information is used or disclosed to carry out treatment, payment, or health care operations. St. Joseph's Ear, Nose & Throat Clinic is not required to agree to such requested restrictions; however, if St. Joseph's Ear, Nose & Throat Clinic does agree to PATIENT's requested restriction(s), such restrictions are then binding on St. Joseph's Ear, Nose & Throat Clinic.

At all times, PATIENT retains the right to revoke this Consent. Such revocation must be submitted to St. Joseph's Ear, Nose & Throat Clinic in writing. The revocation shall be effective *except* to the extent that St. Joseph's Ear, Nose & Throat Clinic has already taken action in reliance on the Consent.

St. Joseph's Ear, Nose & Throat Clinic may refuse to treat PATIENT if PATIENT (or an authorized representative) does not sign this Consent Form (except to the extent that St. Joseph's Ear, Nose & Throat Clinic is required by law to treat individuals). If PATIENT (or authorized representative) signs this Consent Form and then revokes Consent, St. Joseph's Ear, Nose & Throat Clinic has the right to refuse to provide further treatment to PATIENT as of the time of revocation (except to the extent that St. Joseph's Ear, Nose & Throat Clinic is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time _____ AM/PM

Signature of Patient

Please print name

Signature of witness

Person Signing on behalf of Patient *

Please print name

Please print name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

