MID-MARYLAND ENT SPECIALISTS, P.A.

CONSENT TO USE OR DICLOSE INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information (protected health information or P.H.I.) by Mid-Maryland ENT Specialists ("Facility") in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for P.H.I. for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for P.H.I. at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by a written request.

Patient retains the right to request that the Facility further restrict how his/her P.H.I. is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions: however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation much be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Facility has already taken action in reliance on the Consent. The Consent can be revoked in writing to the Facility.

The Facility may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility as the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

COMMUNICATION AUTHORIZATION

1. The Provider may contact me at my home/work phone numbers, or my home address regarding my diagnosis, results, treatment and care, or payment. I may give permission for other means of communication, such as e-mail or cell phone. Appointment reminders will come through our automated phone system.

   ☐ Yes, you may e-mail me at _____. You are authorizing, Follow My Health, our patient portal, to have access to your e-mail. You will have access to your medical record through the portal. However, your e-mail is not required.

   ☐ Yes, you may call my cell phone at _____. I understand cell phones are NOT considered a private/secure method of communication.

2. I authorize Mid Maryland ENT Specialist's to share medical/billing information about my care/account to the following: (e.g. spouse, partner or family member)

Name(s)	Relationship(s)	Phone(s)
_____	_____	_____
_____	_____	_____

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AT MY REQUEST 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.

_____ _____
Print Patient's Name Date

_____ _____
Patient's Signature or Legally Responsible Person's Relationship to Patient