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Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment, and Health Care Operations

As a condition of providing treatment to you, Midwest Ear, Nose & Throat, LLC must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of Midwest Ear, Nose & Throat, LLC

You may revoke this consent at any time by notifying Midwest Ear, Nose & Throat, LLC in writing, except to the extent Midwest Ear, Nose and Throat, LLC has taken action and reliance on your consent.

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations.

Please refer to the Notice of Privacy Practices for Protected health Information ("Privacy Notice") for a more complete description of the uses and disclosures that Midwest Ear, Nose & Throat, LLC may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

Midwest Ear, Nose & Throat, LLC has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Midwest Ear, Nose & Throat, LLC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Midwest Ear, Nose & Throat, LLC is not required, however, to agree to such requested restrictions. If however, Midwest Ear, Nose & Throat, LLC agrees to the requested restriction, Midwest Ear, Nose & Throat, LLC will honor the request and it will be binding on Midwest Ear, Nose & Throat, LLC

I hereby consent to the use and disclosure by Midwest Ear, Nose & Throat, LLC its work force, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

_____
Signature

_____
Signature of Personal Representative of Patient

_____
Description of Representative's Authority to Act for Patient

Date: _____