

ENTAA CARE, P.A.

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

ENTAA Care, P.A. (ENTAA Care) obtains and maintains health information relating to your past, present or future physical or mental condition, provision of health care or payment for health care, referred to as Protected Health Information. This Protected Health Information may be used or disclosed by ENTAA Care for purposes of treatment, payment, or health care operations, including, but not limited to:

- sending information to my referring doctor;
- planning for my care and treatment;
- calling me with appointment reminders and lab results;
- submitting a claim to my insurer or health plan; and
- assessing the quality of care provided to me.
- ENTAA Care may leave a personal detailed message at the following phone number

\_\_\_\_\_.

ENTAA Care's Notice of Privacy Practices contains a more complete description of how my Protected Health Information may be used and disclosed and how I can obtain access to this information. I understand that ENTAA Care reserves the right to change its Notice and practices and I can request a copy of its current Notice.

I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by ENTAA Care. ENTAA Care is not required to agree to my request but if ENTAA Care does agree, the requested restrictions will be binding.

I further understand that, at anytime, I may revoke this consent in writing, except to the extent that ENTAA Care has already taken action in reliance on it. PHI- Revocation becomes effective upon the day ENTAA Care receives written notice from the patient or legal representative.

**Consent to Disclose PHI: (Personal Health Information)**

By signing this form below, I consent to ENTAA Care's use and disclosure of my Protected Health Information for the purpose of treatment, payment, and/or health care operations as noted above and acknowledge that I may request a copy of the Privacy Notice of ENTAA Care, P.A.:

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

