

Nina J. Lee-Tall, M.D, Inc.

Otolaryngology Head and Neck Surgery
Adult and Pediatric Ear Nose and Throat
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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, our patient. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review and receive a copy of our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

With my consent, Nina J. Lee-Tall, M.D. and staff may call my home or other designated location _____ and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Nina J. Lee-Tall, M.D. and staff may e-mail or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and advertisements for our services.

I have the right to request that Nina J. Lee-Tall, M.D. and staff restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if does, it is bound the agreement.

By signing this form, you consent to use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, sign by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

If I do not sign this consent, Nina J. Lee-Tall, M.D. and staff may decline to provide treatment to me.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and I have had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing with a verifiable signature on file, at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this Consent.

Signature of Patient or Legal Guardian

Date

Print Name of Patient

Relationship to Patient

Print Name of Guardian

Witnessed By:

Please list any relatives or friends we may release your health information to, should they inquire about it:

