CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Proctor ENT, PLC
Todd B. Proctor, MD
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Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession (collectively "**Protected Health Information**"). The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For a more complete description of how the office may use or disclose your Protected Health Information, please carefully review the **Notice of Privacy Practices Form** that this office has prepared and is furnishing to you today.. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment", "payment" and "health care operations".

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES FORM WILL BE MADE AVAILABLE TO YOU BY CONTACTING **PROCTOR ENT, PLC**.
YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT IS AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.
YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.
BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICES'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICES NOTICE OF PRIVACY PRACTICES FORM TO TAKE WITH YOU.

Below is a list of people that I would like my Protected Health Information shared with:

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PATIENT SIGNATURE **PRINT NAME** **DATE SIGNED**