

Patient Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I have been informed by you of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my health information. I have the right to review such Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices occasionally and that I may contact this organization at any time to obtain a current copy of them.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name	Signature
Date	Relationship to Patient if Signed by Representative
Align ENT + Allergy I	Partner Practices may release my medical information to:
Name	Relationship to Patient