

# Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement with Consent



I acknowledge that I have received a copy of Ear, Nose and Throat Specialists of Alaska (ENTSA) Notice of Privacy Practices and understand I have a right to review prior to signing this document. I also consent to the use or disclosure of my protected health information (PHI) by ENTSA for the purpose of treatment, payment and health care operations.\*

## **I UNDERSTAND:**

- Service to me may be conditioned upon my consent as evidenced by my signature on this document.
- I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of the practice. ENTSA is not required to agree to the restrictions that I may request. However, if ENTSA agrees to a restriction that I request, the restriction is binding on ENTSA.
- I have the right to revoke this consent, in writing, at any time, except to the extent that ENTSA has taken action in reliance on this consent.
- My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, and a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me; or, there is a reasonable basis to believe the information may identify me.

## **THE NOTICE OF PRIVACY PRACTICES DESCRIBES:**

- The types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations performed by ENTSA.
- My rights and the duties of ENTSA with respect to my PHI.

ENTSA reserves the right to change its privacy practices. All current or revised notices can be obtained by contacting the office at 907-373-1410.

My health information may also be released to: \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian  
(If patient is a minor)

\_\_\_\_\_  
Date

*\*Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization. Health care operations include the necessary administrative and business functions of our office.*