EAR NOSE & THROAT CLINIC

FAIRBANKS HEARING & BALANCE CENTER

BOREALIS MEDSPA

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PATIENT CONSENT FORM

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

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

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its policy from time to time and that I may contact you to obtain a current copy.
I understand that I may request in writing that you restrict how my private information is used or disclosed and that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.
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:_____

Relationship to Patient:_____

Date:_____

For Office Use Only:
HIPAA Policy Form REFUSED (date)_____Initials_____