HIPPA PRIVACY PRACTICE NOTICE
The offices of John R. Simpson, MD, FACS
Northeast Georgia ENT-Head & Neck Surgery PC
Winder Ear, Nose & Throat Center, PC.
EFFECTIVE 5/01/2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. COPIES OF THESE PRIVACY POLICIES ARE READILY AVAILABLE UPON YOUR REQUEST.

CONSENT TO TREATMENT, AUTHORIZATIONS, AND MEDICAL RELEASE

I authorize John R. Simpson, MD; Northeast Georgia ENT Head & Neck Surgery, P.C; and Winder Ear, Nose and Throat Center, hereafter collectively referred to as NEGA ENT, to give me reasonable and proper medical care by today's standards.
I consent to NEGA ENT's use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as protected health information or PHI) for the purposes of:

- Providing medical treatment.
- Obtaining payment and reimbursement.
- Obtaining authorizations from my insurance for tests.
- Requesting healthcare services from other providers.
- Cooperating with other providers in my medical treatment.
- Fulfilling requests for information when specifically authorized by me
- Doing all other things directly related to providing healthcare to me.

The above purposes and all other uses are known collectively as treatment, payment, and other healthcare operations or TPO. I authorize any physician or healthcare facility to provide upon request any PHI to NEGA ENT when needed for the purposes of TPO. I authorize release of my medical records to NEGA ENT including human immunodeficiency virus, psychiatric, drug/alcohol records, venereal disease, and other statutory protected diseases as necessary for continued medical care.
I consent to NEGA ENT discussing any or all of my medical care including my evaluation, treatment, and diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, Human immunodeficiency virus (HIV), HIV related opportunistic infections, pregnancy, billing, or appointments with the following person(s):
PLEASE LIST A SPOUSE OR FAMILY MEMBER TO RELEASE YOUR INFORMATION IN THE EVENT YOU ARE NOT ABLE TO RECEIVE THE RESULTS OF ANY EXAMINATION ORDERED BY NEGA ENT.

1. Name: _____Relationship:_____

2. Name:_____ Relationship:_____

I consent to allow NEGA ENT to leave a message on my answering machine or voicemail regarding my appointment, bill, or test results. I also take responsibility for providing enough information in order for the office staff to contact me efficiently by mail, telephone, and other forms of communication if necessary. My preferred contact phone number is

1._____2._____

My email address is _____

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing. NEGA ENT's Notice of Privacy Practices and Patient Bill of Rights is posted on the website and I may obtain a copy if I so desire by requesting a copy.

www.johnsimpsonmd.com

I understand that should I choose not to consent to the terms and conditions of NEGA ENT the practice has the right to and will withhold treatment except where required by law.

Patient Name (Print): _____Date of Birth:_____

Patient Signature (or Guardian) :_____ Date:_____

This written consent is subject to revocation at any time by writing to the physician or practice which is to release the information except to the extent that this physician or practice has already acted in reliance on this consent. With the exception of mental health, HIV-related information or drug &/or alcohol abuse records, once your health information is disclosed, it may be re-disclosed by the recipient and may no longer be subject to state or federal law protections. To revoke this consent, simply notify the practice in writing and return it to the physician's office. If not previously revoked, this consent will remain in force from

_____to_____

(Today's date) (Specify date consent will expire, not to exceed 1 year.)

The health insurance portability and accountability act of 1996 prohibits the use and disclosure of protected health information for treatment, payment, and other health care operations without a signed consent and prohibits the use and disclosure of protected health information for non healthcare related activities without specific and explicit authorization.