CONSENT TO TREATMENT, AUTHORIZATIONS, AND MEDICAL RELEASE

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.

I authorize The offices of John R. Simpson, MD; Northeast Georgia ENT Head & Neck Surgery, P.C. and Winder Ear Nose and Throat Center and Physicians Hearing Centers, hereafter collectively referred to as ***The Offices*** to give me reasonable and proper medical care by today's standards.
I consent to ***The Offices'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.
- Communicating and promoting all locations and services available through The Offices.

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 ***The Offices*** when needed for the purposes of TPO. I authorize release of my medical records to ***The Offices*** including human immunodeficiency virus, psychiatric, drug/alcohol records, venereal disease, and other statutory protected diseases as necessary for continued medical care.
I consent to ***The Offices*** 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 TO IN THE EVENT YOU ARE NOT ABLE TO RECEIVE THE RESULTS OF ANY EXAMINATION ORDERED BY THE OFFICES.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I consent to allow ***The Offices*** 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 for the office staff to contact me efficiently by mail, telephone, and other forms of communication.
My preferred contact phone number is 1._____ 2._____.
I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing. ***The Offices*** Notice of Privacy Practices and Patient Bill of Rights is posted on the website ***www.johnsimpsonmd.com*** and I may obtain a copy if I so desire by requesting a copy. I understand that should I choose not to consent to the terms and conditions of ***The Offices*** 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: _____

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.