HIPAA PRIVACY ACT
PATIENT CONSENT FORM

The Health Insurance Portability and Protection Act (HIPAA), requires that all medical providers, insurance companies and all other entities, put in place controls to ensure that your personal medical information is safe and secure.

By signing this form, you consent to our use and disclosure of protected health information about you, your treatment, payment and healthcare operations/procedures. You have the right to revoke this consent **IN WRITING**; except when we have already made disclosures in reliance on your prior signed consent or as required by law. If you choose to decline, **PLEASE PROVIDE A WRITTEN DECLINATION** so we may have a copy.

Our Notice of Privacy Practices provides information about how we may use and disclose protected healthcare information about you as the patient. You have the right to review our notice before signing this consent. Copies are available upon request at the Front Desk.

_____ _____ _____/_____/**20**____
Responsible Party (Print) Signature of responsible party Date

Authorization to Release of Information

I authorize the release of medical records to/from another Physician said assignee; who is consulting in my care to Joseph L. Mikus, MD and Cara Housden, PA-C *and/or* Shenandoah Head and Neck Specialists, PLLC to assist in the continuity of my care.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of my appointments, insurance/billing inquiries, results of testing and medical conditions/care.
If there is an additional individual you would like to add release of information to; please provide **VERBAL CONSENT** Swith our associates to place on file, until HIPAA Privacy form is up to date.

1. Name: _____ Relationship to patient: _____
   Phone number of the above: (_____) _____ - _____
2. Name: _____ Relationship to patient: _____
   Phone number of the above: (_____) _____ - _____
3. Name: _____ Relationship to patient: _____
   Phone number of the above: (_____) _____ - _____

I hereby authorize my listed Emergency Contact to be included in the above: Initial: _____

I authorize the staff of this office to leave messages on my voicemail regarding appointments, insurance information and to leave messages to call the office to discuss medical issues or concerns with my care.

Please call (check preferred contact): (_____) _____ - _____

[ ] Home [ ] Cell [ ] Work

If Unable to reach me (please check the preferred option)
[ ] Leave a detailed message
[ ] Please leave a message asking me to return your call

You have the right to revoke this consent at any time, except for when disclosure has already been made by your prior signed consent. I permit a copy of this authorization to be used in place of the original copy provided.

_____ _____ _____/_____/**20**____
Responsible Party (Print) Signature of responsible party Date