# Consent for the Use or Disclosure of Protected Health Information

Decatur ENT Associates, PC
1218 13th Avenue SE – Decatur, AL 35601

Who can we disclose your medical information to? Be specific. _____
_____
_____
_____

Is there anyone you ***do not*** want to have access to your medical records? Please specify. _____
_____

This authorization is valid for a period of 1 year unless otherwise specified. _____

My signature below indicates that I have been given a copy of the Notice of Privacy Practices and to have any questions answered before signing. We encourage you to read the Notice of Privacy Practices since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. I understand I may request restrictions on the uses and disclosures of my health information at any time by submitting a written request to the address above.

Name (printed) _____

Signature _____

Date _____

I understand that I may revoke this consent at any time by signing below and returning it to the address above. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Name (printed)_____

Signature_____

Date of Revocation Request_____