GemStateENT
& HEARING PROFESSIONALS

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (HIPAA CONSENT)

Protected health information (PHI) will be disclosed or used by Gem State ENT and Hearing Professionals for the purposes of treatment, obtaining payment or supporting day-to-day health care options.

I understand that I have a right to request restrictions on the uses and disclosures of my PHI for the above-stated purpose.

I understand I may revoke this consent in writing at any time. However, any use or disclosure that occurs prior to the date I revoke this consent is not affected.

We may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. Any message we leave may contain confidential information not intended for others. By signing below, you consent to us leaving messages on your answering machine/voicemail/phone via text message.

Please print below.

_____

Mother

_____

Father

_____

Legal Guardian