E.N.T. Associates of Worcester, Inc

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REVISED/UPDATED Notice of Privacy Practices Acknowledgement
Full notice available upon request at Front Desk

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may get the complete *Notice of Information Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Information Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Information Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Revised Notice:

- *Release authorizations*: Certain disclosures and uses of protected information will require my authorization. They include: 1. Psychotherapy notes. (The notes of a mental health professional that are separate from the record.) 2. Any information the office will use for marketing. 3. Any sale of the office's patient information.
- *Fundraising*: I can opt out of receiving fundraising material from the office.
- *Restricting information releases*: A patient who pays for a service in full and out of pocket can request that our office not disclose any information about that service to an insurance company. This request must be in writing specifically requesting what information the patient wants to restrict and what insurance company is not to receive it.
- *Breach notification*: This office will notify me in writing if or when a breach in my protected information occurs.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Christopher C. Charon, M.D.

Ear, Nose & Throat Specialist

Charon Sinus Center 145 Pomfret Street Putnam, Ct 06260

Telephone (860)928-7330 Fax (860)928-1907

CONFIDENTIAL COMMUNICATION REQUEST

Patient Name: _____

Patient Date of Birth: _____

As required by the Health insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through Confidential channels.

Would you like to give our office permission to speak with anyone other than yourself (such as a family member, friend, or facility) regarding your medical information? **YES **or** **NO**

IF YES, PLEASE LIST BELOW:

NAME: _____

RELATIONSHIP: _____

TELEPHONE #: _____

Signature: _____

Print Name: _____

Today's Date: _____

If not signed by patient, please indicate relationship to patient: _____

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