Charlene Hickson M.D. & Esperanza Salazar M.D.

Pueblo Ear, Nose & Throat Specialist

1218 S. Pueblo Blvd, Pueblo, CO 81005

719-566-1277 (FAX 719-566-1257)

HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Pueblo Ear Nose and Throat Specialist, P.C. to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct or indirect treatment by others healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Pueblo Ear Nose and Throat Specialist, P.C.

I have also been informed of, and given the right to review and secure a copy of the Pueblo Ear Nose and Throat Specialist, P.C. Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Pueblo Ear Nose and Throat Specialist, P.C. reserves the right to change the terms of this notice at any time and that I may contact Pueblo Ear Nose and Throat Specialist, P.C. at any time to obtain the most current copy of this notice.

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

Printed Name: _____ **Signature:** _____

Date Signed: _____

I wish to be contacted in the following manner ***be sure to fill in contact phone numbers***. If you do not accept blocked calls, any return call may be delayed, unless you remove this feature from your phone.

Home Telephone # _____

Can leave a message with detailed information
OR
Leave a message with a call back number only

Alternate Telephone # _____

Can leave a message with detailed information
OR
Leave a message with a call back number only

☐ **Work Telephone #** _____

☐ Can leave message with detailed information
OR
Leave a message with a call back number only

Written Communication

☐ Can send letter with detailed information
OR
☐ Okay to fax to this number _____

PLEASE INDICATE WHO WE CAN SPEAK TO REGARDING YOUR MEDICAL INFORMATION: (please check all that apply)

☐ Patient only

☐ Spouse or Significant other Name _____ Phone _____

☐ Parents Name _____ Phone _____

☐ Other Name _____ Phone _____

Other Comments: _____

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