Shasta ENT Specialists
Redding Sinus Center
George H. Domb, M.D.

CONSENT TO DISCLOSE

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION:
Your protected health information will be used by Shasta ENT Specialists and Redding Sinus Center or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day healthcare operations of the practice.

NOTICE OF PRIVACY PRACTICES:
You should review the notice of privacy practices for a more complete description of how your protected health information may be used or disclosed. We encourage you to review the notice prior to signing this consent. Please note, in the event of an emergency, your health information may be disclosed.

REQUESTING THE RESTRICTION ON THE USE OF DISCLOSURE OF YOUR INFORMATION:
You may request a restriction on the use or disclosure of your protected health information. Shasta ENT Specialists and Redding Sinus Center may or may not agree to restrict the use or disclosure of your protected health information. If Shasta ENT Specialists and Redding Sinus Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

REVOCATION OF CONSENT:
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received with not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES:
Shasta ENT Specialists and Redding Sinus Center reserves the right to modify the privacy practices outlined in the notice.
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AUTHORIZED DISCLOSURES:
In an effort to protect your health care information yet give you choices, please list any/all of names in relation of those whom we have your permission to discuss appointment dates, times, billing, and medical information. (Example: spouse, significant other, parents, physicians, etc)

Name	Relation
Name	Relation
Name	Relation

SIGNATURE
I have reviewed this consent form and I am in receipt of the Notice of Privacy Practices. I give my permission to Shasta ENT Specialists and Redding Sinus Center to use and disclose my health information in accordance with it.

Signature of Patient or Guardian	Relation
Name of Patient	Date

Staff Signature (If patient refuses to sign)