PHILADELPHIA EAR NOSE & THROAT ASSOCIATES
Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSURE YOUR HEALTH INFORMATION
Your protected health information will be used by **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES
PHILADELPHIA EAR NOSE & THROAT ASSOCIATES is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES** may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or **LINDA MARKS** if you would like additional information or clarification.

It is a violation of the federal privacy standards if **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES** agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or **LINDA MARKS** at the location and contact information listed on the back of the brochure.

Appointment Reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail via "appointment cards" or postcards, or a brief, non-specific message may be left on your answering machine. If you don't approve of these methods and would like alternative reminder methods (i.e. work telephone), please indicate those methods in the space provided (samples of appointment reminders are available upon request).

PHILADELPHIA EAR NOSE & THROAT ASSOCIATES
Authorization of Use and Disclosure of Protected Health Information
Please Complete All Sections of This Form

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES? (Check all that apply)**

_____ **Regular Mail** (please provide address)
_____
_____

_____ **Home Telephone**_____
_____ **Work Telephone**_____
_____ **Cell Telephone** _____
**(I am aware that a cell phone is not a secure and private line)

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES? (Check one)**

_____Yes (if yes, circle home and/or work)
_____No
_____N/A

If "NO", how else may we contact you regarding this information?
_____

Persons Authorized to Receive Information:
Health information **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES** collects or receives about you may be disclosed to the following persons (this may include emergency situations):

_____
Name of person/relation/organization
_____
Name of person/relation/organization
_____
Patient's Printed Name
_____
Patient's Signature
_____
Witness

PHILADELPHIA EAR NOSE & THROAT ASSOCIATES
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Other Uses and Disclosures. Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

_____I would like the following restrictions regarding the use and disclosure of my health information:

_____

_____

_____

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL AND FINANCIAL INFORMATION

The signature below will authorize Drs. Robert Thayer Sataloff, Karen M. Lyons, Robert J. Wolfson, Thomas C. Spalla, Helen Yoo Bowne, Amanda Hu, and/or any associates of the practice to furnish or receive from physician(s)/attorney(s)/insurance company/speech pathologist/audiologist/psychologist/voice teacher/_____any information and/or opinions which they require, or to photocopy the same.

I request that payment of authorized Medicare/insurance benefits be made either to me or on my behalf to Robert Thayer Sataloff, M.D. and any associates of the practice for any services furnished to me by one of the physicians. I authorize any hold of medical information about me to be released to the Health Care Financing Administration and its agents that may be needed to determine these benefits or the benefits payable for related services.

PHOTOGRAPH, VIDEOTAPE OR FILM RELEASE
I hereby agree and consent to be photographed, filmed or videotaped by PHILADELPHIA EAR NOSE & THROAT ASSOCIATES. I understand that this reproduction may be used for educational and training purposes only; my name will not be used.

_____
Patient's Printed Name

_____
Patient's Signature

_____
Witness

PHILADELPHIA EAR NOSE & THROAT ASSOCIATES
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YOU MAY REVOKE THIS CONSENT AT ANYTIME
You may revoke this consent at anytime; however, **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES** requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

Potential for Re-disclosure
The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

CHANGES TO PRIVACY PRACTICES
PHILADELPHIA EAR NOSE & THROAT ASSOCIATES reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES** will notify you of any changes or privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

SIGNATURE
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **PHILADELPHIA EAR NOSE & THROAT ASSOCIATES** to use and disclose my health information in accordance with this consent and the notice provided.

_____	_____
Name of Patient (Print or Type)	Signature of Patient/Date
_____	_____
Patient Representative (Print or Type)	Signature of Representative/Date
_____	_____
Relationship of Patient Representative to Patient	Witness

Consent for Off-Label Use of Medication

Many medications are prescribed routinely for "off-label" uses. This means that the medication (or device) is FDA approved, but the use for which it is being prescribed is not specifically specified in the package labeling on the Physician's Desk Reference. Such prescriptions are extremely common and considered appropriate in the medical profession and by the Food and Drug Administration (FDA); and off-label uses are part of routine medical practice. For example, although proton-pump inhibitors such as Prevacid and Nexium are approved for reflux disease that causes heartburn, they are not approved specifically for reflux disease that causes laryngeal symptoms, although they had been prescribed for and used successfully by many thousands of patients. I understand that the doctor may prescribe an approved medication for an off-label use when the potential benefits to me outweigh any potential risks, and that any significant risks or alternatives will be explained to me.

_____
Signature

_____
Name of Patient (Print or Type)

_____
Signature of Patient/Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

_____
Witness