Comprehensive
Ear, Nose and Throat, P.C.

HIPAA Form

(Required by the U.S. Government)

This notice describes how medical information about you may be used and disclosed and how you or others can get access to this information. Please review it carefully.
Comprehensive Ear, Nose and Throat, PC. is required by law to maintain the privacy of Protected Health Care Information.

I authorize Comprehensive Ear, Nose and Throat, PC. or any of its employees to contact any third party payer and obtain or transfer any of my Protected Healthcare Information that may be of assistance in payment of any medical claim(s).
I authorize any release or transfer of Protected Health Care Information to the Health Care Financing Administration (HCFA) for the purpose of claims management.
I also authorize any release or transfer of any Protected Healthcare Information either in writing, or by electronic means to any employees of Comprehensive Ear, Nose and Throat, PC. or any other health care entities including the West Michigan Regional Delivery Network and Residents In Training for the purpose of continued patient care (treatment) or health care operations.
I authorize Comprehensive Ear, Nose and Throat, PC. or any of its employees to contact the patient or authorized agent of the patient for the purpose of appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the patient.
I understand that the patient or authorized agent for the patient may inspect Protected Healthcare Information in the possession of Comprehensive Ear, Nose and Throat, PC. if desired. One photocopy of Protected Healthcare Information will be provided free of charge if requested in writing. Any further copies will be at the expense of the patient or authorized agent of the patient.
Any other use of the patient's Protected Healthcare Information will not be allowed unless authorized in writing by the patient or an authorized agent of the patient.
I understand that the authorizations detailed above will expire upon termination of patient care by Comprehensive Ear, Nose and Throat, PC. or any of its employees.
I may at any time specifically revoke portions, or all of the above authorizations concerning Protected Healthcare Information by contacting Comprehensive Ear, Nose and Throat, PC. in writing.
I understand, however, that revocation may seriously jeopardize my continued health care, and will not allow any transfer of Protected Healthcare Information or any billing services to be done on my behalf.
I understand that if I do not sign this HIPPA form, then I can still obtain healthcare at Comprehensive Ear, Nose and Throat, PC., but no billing can be done on my behalf, and no

Protected Healthcare Information can be transferred. All transactions with Comprehensive Ear, Nose and Throat, PC. will be on a cash, check or credit card basis **only**.
I understand that Comprehensive Ear, Nose and Throat, PC. reserves the right to amend this document if there are any applicable changes in Federal Law in regards to Protected Health Care Information. Any change or revision in Comprehensive Ear, Nose and Throat, PC.'s policies concerning the above must be provided to the patient in writing.
If you feel that Protected Healthcare Information is not secure: The patient or authorized agent of the patient is encouraged to immediately address any violations of the above with the Office Manager of Comprehensive Ear, Nose and Throat, PC. by mail or phone at:

HIPPA Compliance Officer
970 Parchment Dr. SE. #102
Grand Rapids, MI. 49546
Ph: (616) 942-0380. Fax: (616) 942-8640

All concerns will be addressed in a timely and fair manner. Difficulties that are not resolved should then be addressed to the Secretary of the United States Department of Health and Human Services at:

Office for Civil Rights Region 5
US Department of Health and Human Services
233 N. Michigan Ave. #240
Chicago, IL 60601
Ph: (312) 886-2359 Fax: (312) 866-1807

Signature of the Patient or Authorized Agent for the Patient:

______________________________ date: ____________________

Please list person(s) that we may release Protected Healthcare Information to:

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Thank You For Your Patience!