Crossville Location:
49 Cleveland St, Suite 220
Crossville, TN 38555
Main Line: 931-219-9990
Fax Number: 931-717-1180

Oak Ridge Location:
700 S. Illinois Ave, Suite A104
Oak Ridge, TN 37830
Main Line: 865-383-0737
Fax Number: 865-383-0015

Consent to the Use and Disclosure of Health Information

Name _____ **DOB**_____

Our Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care options.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

I authorize my medical information to be discussed/disclosed to:

Family member or friend _____
FULL NAME

Physician_____ Other _____
FULL NAME **FULL NAME**

Detailed messages regarding test results and appointment reminders can be left on answering machine or voicemail:

Please list Phone # _____ **YES NO**

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

I acknowledge that I have been provided with an opportunity to review the Notice of Privacy Practices for Rocky Top ENT & Allergy.

_____ _____

Signature of Patient or Legal Representative **Date**