Western Michigan ENT
Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for WMENT to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). WMENT's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. WMENT reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to WMENT's Privacy Officer at 1806 E Parkdale Ave Suite 3, Manistee, MI 49660.

With this consent, WMENT may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and any calls pertaining to my clinical care including but not limited to laboratory results.

With this consent, WMENT may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that WMENT restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to WMENT's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If I do not sign this consent, or later revoke it, WMENT may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian