# EAR, NOSE & THROAT CONSULTANTS OF NEVADA

W.W. Schroeder, M.D., F.A.C.S., F.A.A.P. David Foggia, M.D. Ashley Sikand, M.D., F.A.C.S.
Frederick Goll, III, M.D. Larry Yu, M.D. Timothy Tolan, M.D.
Jonathan Salinas, M.D. Charles Abdo, M.D. James Heroy, III, M.D., F.A.C.S.
Daniel Kim, D.O. Michael Watts PA-C

PHONE: (702) 792-6700 FAX: (702) 792-7198 www.entc.com


## Using and Disclosing Protected Health Information for Involvement in the Individual's Care and Notification Purposes

As per Notice of Privacy practices, Ear, Nose and Throat Consultants of Nevada must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patient's family members, or friends involved in their care.
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.
You may request a restriction on the use or disclosure of your protected health information. Ear, Nose & Throat Consultants of Nevada may or may not agree to restrict the use or disclosure of your protected health information. If Ear, Nose & Throat Consultants of Nevada agree 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.
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 will not be affected. Ear, Nose & Throat Consultants of Nevada reserves the right to modify the privacy practices outlined in the Notice.

This document will serve as a written agreement between _____ and Ear, Nose & Throat Consultants of Nevada as a list of those designated by the patient as having direct involvement with the patient's care.
In the event you are unable to sign a medical release for your records, please provide us with a list to include next of kin and/or persons names you will authorize us to release your medical records to. Persons noted below will have to fill Medical release and show proper Identification before receiving records. It will be the patient's responsibility to update as necessary.

**Please mail me a copy of my records. (This will be processed upon request by phone or mail.)**

_____ _____ _____
Patients Name Patients Signature DOB

**Next of Kin/Family Members**

Name: _____Relationship_____Phone_____

Name: _____Relationship_____Phone_____


**Northwest Office**
**7040 Smoke Ranch Road**
**Las Vegas, NV 89128**

**Green Valley Office**
**3195 St Rose Parkway**
**Suite 210**
**Henderson, NV 89052**
**(Mailing address)**

**Southwest Office**
**8840 W Sunset Road**
**Suite A**
**Las Vegas, NV 89148**

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**I authorize for Ear, Nose & Throat to release Medical records to the following Medical Providers.**

Doctors or Facility Name _____Phone #_____Fax #_____

Doctors or Facility Name _____Phone # _____Fax#_____

**Per My Permission-Leave Medical Information on my answering machine**-

**YES** ☐ **NO** ☐

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my revocation to Medical Records Department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtain from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify a date, **this authorization will expire one (1) year from the signature on this form.**

_____Date_____
Signature of Patient

_____Date_____
Signature of Guardian or Personal Representative

_____
Patient number


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