



BUCKHEAD ENT

2045 Peachtree Road N.W.
Suite 500
Atlanta, GA 30309
(404) 350-7966

Dr. Keith M. Dockery, M.D.

Patient Consent for the Use and Disclosure of Protected Health Information

I hereby give my consent for Buckhead ENT to use and disclose protected health information (PHI) about me to carry out treatment, billing and routine healthcare operations of our medical practice. I have read the Notice of Privacy Practices, which provides a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, Janice Willis, at Buckhead ENT's office at 2045 Peachtree Road, Suite 500, Atlanta, GA 30309.

With consent, Buckhead ENT may call my home or other alternative locations and leave a message or voicemail regarding appointment reminders, insurance collection items, and any calls pertaining to my clinical care, including laboratory, MRI, CT, or sleep study results.

With this consent, Buckhead ENT may mail to my home or alternative location any items that assist the practice in carrying out their healthcare operations.

With this consent, Buckhead ENT may email to my home or alternative location any items that assist the practice in carrying out their healthcare operations.

I have the right to request that Buckhead ENT restrict how it uses or discloses the Protected Health Information (PHI) to carry out their healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Buckhead ENT's use and disclosure of my PHI to carry out their healthcare operations.

I may revoke this consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Buckhead ENT may decline to provide treatment to me.

I wish to be contacted in the following manner

(Please check all that apply)

Home Telephone _____

- OK to leave message with detailed information
- Leaving message with call-back number only

Work Telephone _____

- OK to leave message with detailed information
- Leaving message with call-back number only
- OK to fax to this number

Written Communication

- OK to mail to my home address
- OK to mail to my work/office address

I understand that by signing this form, I am giving Buckhead ENT., specifically Dr. Keith M. Dockery, the authorization to use my protected health information to carry out their healthcare operations. I further understand that Buckhead ENT cannot guarantee the confidentiality of my PHI when leaving messages on the telephone answering machines or on voice mail lines.

Signature of Patient or Legal Guardian _____ Date _____