ENT ASSOCIATES
HIPAA

I authorize **Harold W Blevins, MD, PSC** dba **ENT ASSOCIATES** and their physicians to treat me/my child. I hereby consent to **Harold W Blevins, MD, PSC** dba **ENT ASSOCIATES** using or disclosing my protected health information for the purpose of providing treatment, obtaining payment for healthcare services rendered to me/my child, or to carry out the practice's health care operations. I also consent to the practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

E-PRESCRIBING CONSENT

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress had determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions**—Gives the prescriber information about which drugs are covered from the patient's drug benefit plan.
- **Medication history transactions**—Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**—Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that **Harold W Blevins MD PSC** dba **ENT ASSOCIATES**, can request and use your prescription medication history and medical history from other healthcare providers and /or third party providers and pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to **Harold W Blevins MD PSC** dba **ENT ASSOCIATES**, to enroll me in the ePrescribe Program and for medical treatment. I have had a chance to ask questions and all of my questions have been answered to my satisfaction.

Date: _____ **Signature:** _____

Print: _____

I authorized the person/persons below to receive and discuss with you my protected health information, account information and any other of the practice's health care operation concerning myself.

Please Print

Person: _____

Relationship _____

Person: _____

Relationship _____

Person: _____

Relationship _____

You have my permission to leave my medical information on :
Choose All that Apply: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Fax

You have my permission to leave my financial/billing information on :
Choose All that Apply: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Fax