

MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your medical information:

- The right to request restrictions on certain uses and disclosures of your Protected Health Information (PHI). We are not required to agree to your requested restriction, but if we do, we will honor it.
- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with written explanation for the denial and information regarding further rights you would have at that point.
- The right to receive an accounting of the disclosures of your medical information in the six years prior to your request (following April 14, 2003), except for disclosures for treatment, payment, or practice operational purposes, disclosure pursuant to an authorization and certain other specific disclosure types.
- The right to request a paper copy of this Notice of Privacy Practices / or Protected Health Information.
- The right to complain to the Practice and/or to the U.S. Department of Health and Human Services, if you believe that the Practice has violated your privacy rights. To complain to the Practice, please call:

JANICE KAY, Compliance Officer at (601) 709-7700

If you choose to file a complaint, you will not be retaliated against in any way.

THIS NOTICE IS EFFECTIVE AS OF January 1, 2004.

I have received and had an opportunity to ask questions concerning the Practice's Notice of Privacy Practices for Protected Health Information.

Signature of Patient

Date

I authorize the Physicians of Mississippi Ear, Nose and Throat Surgical Associates, P.C. to provide treatment and use my Health information for treatment, payment, and healthcare operations (TPO), which includes submitting information to my insurance company for the purpose of processing claims. I further authorize non-Practice labs and radiology centers and Pathologists and Radiologists who may interpret and/or report on diagnostic tests ordered by the Practice to provide such treatment and use my Health Information for billing and payment. I am responsible for payment of services rendered to me by the Practice. If I am under 18, then the parent/guardian requesting treatment assumes responsibility. Full payment is due at the time of service unless I am covered by an accepted insurance or third party coverage plan. I understand that if my account should ever require action by a collection agency or attorney in order to collect the balance owed, then fees charges by these agents may be added to the balance due on my account.

I hereby acknowledge and agree to accept the policies stated above.

Signature of Patient

and/or Parent, if Patient is under 18

Date