JACKSON EAR, NOSE AND THROAT CLINIC, P.A.

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 restrictions, 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 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:

DONNA MOSS, Compliance Officer at (601) 352-7655

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

This notice is effective as of January 1, 2003.

I HAVE RECEIVED AND HAD AN OPPORTUNITY TO ASK QUESTIONS CONCERNING THE PRACTICE'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

_____ _____

Patient of Patient's Representative Date

I authorize the Physicians of Jackson Ear, Nose and Throat Clinic to provide treatment and use my Heath Information for treatment, payment, and healthcare operations, which includes submitting information to my insurance company for the purpose of processing claims. I further authorize non-Practice labs and radiology centers and Pathologist and Radiologist who may interpret and/or report on diagnostic tests ordered by the Practice to provide such treatment and use my PHI for billing and payment. I am responsible for payment of services rendered to me by the Practice. If I am under 18, parent/legal 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, fees charged by these agents my be added to the balance due on my account.

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

_____ _____

Signature of Patient or Parent (if patient under 18) Date