Central ENT Consultants, PC Form updated 12/11/20

HIPAA / PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that my written permission is necessary for protected health information to be released to anyone including family or friends who may be involved in my treatment or care except as permitted or required by law.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Please see the front desk to review a copy of our Privacy Practices.

I HEREBY GIVE PERMISSION FOR MEDICAL INFORMATION TO BE LEFT ON MY VOICEMAIL / ANSWERING MACHINE AT THE FOLLOWING NUMBER(S):

CELL #: _____ HOME #: _____ WORK # : _____

I HEREBY GIVE PERMISSION FOR THE FOLLOWING NAMED PERSON (S) TO RECEIVE MEDICAL INFORMATION ON MY BEHALF:

NAME: _____ RELATIONSHIP: _____PHONE NUMBER:_____

NAME: _____ RELATIONSHIP: _____PHONE NUMBER:_____

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Patient's Printed Name: _____ Patient's DOB: _____ / _____ / _____

Patient/Parent/Guardian Signature: _____

Today's Date: _____ / _____ / _____