

Authorization to Release Medical Health Care Information

Everett Ear Nose Throat Sinus and Allergy

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The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance provider and primary care doctor, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friend (including spouse)
<p>I give the following named person(s) authorization to take messages or speak with the office of Everett E.N.T. on my behalf regarding (please check all items authorized).</p> <p><input type="checkbox"/> Appointments <input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Insurance <input type="checkbox"/> Other(explain) _____</p> <p>Name of authorized person(s): _____ Relationship _____</p> <p>Name of authorized person(s): _____ Relationship _____</p> <p>Name of authorized person(s): _____ Relationship _____</p> <p>Name of authorized person(s): _____ Relationship _____</p>
Authorization to Leave Health Information by Alternate Means
<p>Everett ENT will use any and all numbers provided by patient on the Patient Registration Form to leave messages on voice mail for reminder calls and other patient/Everett ENT matters.</p> <p><input type="checkbox"/> I have read</p>
<input type="checkbox"/> DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, I must specifically authorize the release of this information relating to such diagnosis, testing or treatment.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: _____ Date of Birth _____
Please Print Name

Signature of patient or patient's authorized representative

Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal rep.)