HIPAA PATIENT COMMUNICATION FORM

It is the office policy of Anne Arundel ENT (Mid-Atlantic ENT, LLC) not to release confidential medical information regarding your treatment to family members or friends, except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends or caretakers/babysitters, please indicate that below. Please complete information below to anyone you authorize to receive information regarding your treatment. At any point, you can revoke this authorization. Any changes to this form must be made in person or over the phone.

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

I do **NOT** wish to list anyone at this time:

_____
Patient Initials

This authorization will automatically expire 365 days from today's date.

Who would you like us to contact

IN CASE OF EMERGENCY?

I **decline** listing an emergency contact:

_____
Patient Initials

Name: _____ Relationship: _____

BEST phone number to reach emergency contact: _____

Patient's Name: _____ **Patient's DOB:** _____

Patient/ Guardian's Signature: _____ **Today's Date:** _____