SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

PATIENT COMMUNICATION AUTHORIZATION

Patient Name (Print): _____ Date of Birth: _____

Patient Preferred Method of Contact: ☐ Home Phone ☐ Cellphone ☐ Work Phone ☐ Email ☐ Text ☐ Written

Is the practice able to leave information on the patient's or guardian's answering machine or voicemail regarding the patient's medical care and test results? ☐ Yes ☐ No

Release of Confidential Information:

In completing the bottom of this form, you are **authorizing** that the following person(s) be considered as a limitation to the use and disclosure of your protected health information. If at any point you would like to restrict the person(s) listed below from your personal health information, please fill out a Restriction Form, and said person(s) will be removed. This form should be updated every year.

Southwest Idaho Ear, Nose and Throat, P.A., and Southwest Idaho Surgery Center, Inc. are authorized to communicate with the following individuals, as indicated, regarding the patient's protected health information:

Name Relationship Phone Number

Authorization Type: ☐ Full Access ☐ Emergency Contact ☐ Accounting ☐ Messages

Name Relationship Phone Number

Authorization Type: ☐ Full Access ☐ Emergency Contact ☐ Accounting ☐ Messages

Name Relationship Phone Number

Authorization Type: ☐ Full Access ☐ Emergency Contact ☐ Accounting ☐ Messages

_____ _____

Signature of Patient or Legal Guardian Date

Note: Minimal information will be provided to the above-authorized person(s). If detailed account access is needed, you will be required to provide a letter of power of attorney that has been notarized for HIPAA compliance.