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: ☐ Medical Chart (e.g. Progress Notes, Lab Tests/Results, Imaging, Diagnosis/Care Plan)

☐ Emergency Contact Only ☐ Billing Only ☐ Any/All Information

Name: ________________________________ Relationship: _____________ Phone Number: ______________________

Authorization Type: ☐ Medical Chart (e.g. Progress Notes, Lab Tests/Results, Imaging, Diagnosis/Care Plan)

☐ Emergency Contact Only ☐ Billing Only ☐ Any/All Information

Name: ________________________________ Relationship: _____________ Phone Number: ______________________

Authorization Type: ☐ Medical Chart (e.g. Progress Notes, Lab Tests/Results, Imaging, Diagnosis/Care Plan)

☐ Emergency Contact Only ☐ Billing Only ☐ Any/All Information

This authorization will remain in effect one year from date signed or:

☐ Five (5) years from date signed

____ ______________________________

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.