ENT PHYSICIANS, INC.

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Occasionally, family members, caretakers, or other representatives may contact our office requesting information to assist in the patient's care. In order for us to protect your health information, please indicate specific individuals or agencies with whom we may discuss the patient's appointments, care or treatment plan with.

_____'s protected health information may be shared with:
Print Patient's Name

Name Phone Relationship (Spouse/Child/Parent/Other, Etc.)
_____
_____
_____

Is there anyone who is specifically restricted from sharing information with? (If so, have you presented our office with REQUIRED legal documentation to indicate such restriction? Y / N)
Name Phone Relationship (Spouse/Child/Parent/Other, Etc.)
_____
My preferred method of contact is:
___ Phone: 1st contact # _____
2nd contact # _____
___ e-mail (address): _____
___ U. S. mail

Is a detailed message okay? Y / N If not, callback message okay? Y / N

This legal consent will remain in effect indefinitely or until revoked in writing. I understand that without the above information provided, ENT Physicians Inc. will not be permitted to discuss my care with anyone except myself.

_____
Signature of Patient or Legal Guardian Today's Date
EN#_____