TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
www.tallyent.com

Consent to Use or Disclose Information for Treatment, Payment of Healthcare Operations

I accept the terms of the Patient Privacy Notice from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. made available to me as printed and/or posted in the office or available on the website for my review. Protected Health Information may be used for treatment, payment and general practice operation.

I understand that Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. may send letters, postcards, emails, text messages, voicemails, billing statements or communication through the secure patient portal. I acknowledge that Email, voicemail and cell phones are not secure. It is my responsibility, as the patient, to provide accurate and current demographic information including mailing address, phone numbers and private personal email address for communication through the portal.

I understand that medical and financial information may be used by Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. for treatment, payment and normal operation of business. Beyond this, I give permission for my medical files or financial account to be discussed with the people I list on this form.

For patients under the age of 18, a parent or legal guardian must be listed on this form with all permissions given to be authorized for subsequent appointments in our office.

____________________________________ ____________________
Patient's Name Patient's Date of Birth

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•Name: ________________________ DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: ____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ________________________ DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: ____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ________________________ DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: ____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ________________________ DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: ____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

I accept the terms of the Patient Privacy Notice. I consent to the Use or Disclosure of Protected Health Information (PHI) described above for the purpose of treatment, payment or healthcare operations. I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer.

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Patient Signature or Guardian Signature Required

INTERNAL USE ONLY: ______________________ __________________
Employee Signature Date Names Entered