**TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.**

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

________________________________________ ________________________
Patient's Name Patient's Date of Birth

**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, 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 the contacts listed below to be given information regarding my medical treatment/care, financial account, and emergency information 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 for subsequent appointments in our office.**

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•Name: __________________________DOB: ___/___/___ Phone: _______________

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

•Name: __________________________DOB: ___/___/___ Phone: _______________

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

•Name: __________________________DOB: ___/___/___ Phone: _______________

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

•Name: __________________________DOB: ___/___/___ 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 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.**

________________________________________________

**Patient Signature or Guardian Signature Required**

*INTERNAL USE ONLY*: ______________________ ________________
Employee Signature Date Names Entered