



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

I have the right to revoke this consent. Such revocation must be submitted to the Privacy Officer in writing. The revocation shall be effective except in the extent that Tallahassee Ear, Nose & Throat has already acted in reliance within the guidelines of the consent. If the consent is not signed or is terminated after signature, Tallahassee Ear, Nose & Throat may refuse to treat me or continue to treat me (except as required by law to treat individuals) as consent is required for general practice operation.

I understand that Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. may send letters, emails, texts, voicemails, billing statements, or communication through the secure patient portal to the guarantor on my account. I acknowledge that email, voicemail, and cell phones are not secure forms of communication. 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.

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

I give permission for the contacts listed below to be given information regarding my medical conditions and diagnoses (including treatments, financial account, and healthcare options) with:

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If no one, please check here: []

Name: _____ DOB: ___/___/___ Phone: _____ Relationship: _____

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Name: _____ DOB: ___/___/___ Phone: _____ Relationship: _____

Name: _____ DOB: ___/___/___ Phone: _____ Relationship: _____

I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer. A copy of this form can be provided upon request.

Patient Signature or Guardian Signature Required

INTERNAL USE ONLY: _____ Employee Signature _____ Date Names Entered _____