LAKESHORE ENT. P.A.

Due to the Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient.

Patient Name:_____ **Date:**_____

I authorized Lakeshore ENT to release my medical or insurance information as necessary to process my medical condition and coordinate or manage my health care.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give Lakeshore ENT and its physician or employees my permission to discuss freely of my condition, treatment or diagnosis with that person. **YES / NO**

Home Phone: (____)_____ May we leave a message: **YES / NO**

Work Phone: (____)_____ May we leave a message: **YES / NO**

Cell Phone: (____)_____ May we leave a message: **YES / NO**

May we leave a message at one of the numbers listed above about appointments with this office?
YES / NO **HOME / WORK / CELL / PAGER / ALL OF THE ABOVE**

May we leave a message at one of the numbers listed above about lab test, X-Ray test, or appointments with referred physicians?
YES / NO **HOME / WORK / CELL / PAGER / ALL OF THE ABOVE**

With whom may we discuss or release information about your care, treatment, or diagnosis?

Name	Relationship	Phone Number

With whom may we **NOT** discuss or release any information about your care, treatment, or diagnosis?

Name	Relationship

Signature (valid for one year from date shown above)	Printed Name

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and practices with respect to protected health information. If you have any objections to this form, or require the full version of this form, please ask to speak with our HIPPA Compliance Office in person or by phone at 817-573-6673.

Signature below is only to acknowledgement that you have been informed of our Notice of Privacy Practices.

Signature	Printed Name	Date