PATIENT HIPAA COMMUNICATION AUTHORIZATION FORM

Patient Name:_____ **DOB:** _____

Family & Friends: It is the policy of Chesapeake Ear, Nose, and Throat: A Division of CADENT LLC, not to release confidential medical information regarding your treatment to anyone except for (i) parent/legal guardian (if under 18 years of age), (ii) persons authorized by the patient, (iii) anyone we may reasonably infer from the circumstances such as having anyone in the exam room with you, we will assume, unless you verbally object, that the person is entitles to receive information regarding your treatment, (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you want your medical information to be provided to anyone, please indicate below, so that we may best serve your wishes. By signing this document, you authorize the following persons to receive information, as requested, regarding your care and treatment. Updates to this form must be made in person and annually.

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

Date: _____

Patient Name: _____ Patient Signature:_____

For Office Use : _____

Entered into EMR _____ **Expiration Date** _____ **Staff Initials** _____