# HIPAA PATIENT COMMUNICATION FORM

It is the office policy of Anne Arundel ENT (Mid-Atlantic ENT, LLC) not to release confidential medical information regarding your treatment to family members or friends, except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled 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 anticipate that you will need or want your medical information to be provided to family members, friends or caretakers/babysitters, please indicate that below.

May we **text** you? Yes No
May we **email** you? Yes No

The text will be sent from our EMR system with the phone number of **410-834-4712.**

Preferred email address:_____

By signing below, you authorize the following people to receive information regarding your treatment. At any point, you can revoke this authorization. Updates must be made in writing.

***This authorization will automatically expire 365 days from today's date.***

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation: _____

I do **not** wish to list anyone at this time: _____ (Pt initials)

Who would you like us to contact ***IN CASE OF EMERGENCY?***

Name: _____ Relationship: _____

**BEST** Phone Number to reach contact: _____

If you wish to add names later on, please confirm in writing or call our staff directly.

I **decline** listing an emergency contact: _____ (Pt initials)

Patient's Name: _____ Patient's DOB: _____

**Patient's Signature:** _____ **Today's Date:** _____

**Staff Witness:** _____ **(Employee initial and date)**