Frisco Family ENT

Phone: 214-374-8264 Fax: 214-297-0073

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Frisco Family ENT, must have my consent. Therefore, I authorize Frisco Family ENT to disclose my PHI as described in the HIPAA Notice of Privacy Practices, to the recipients listed below:
Description of the information to be disclosed (check all that apply)

☐ All Information ☐ Test Results ☐ Appointments ☐ Surgeries ☐ Billing/Account Information ☐ Other

I specifically authorize Frisco Family ENT to use and disclose verbally, or fax the following types of ***super-confidential information*** as stated in the NOPP (check all that apply):

☐ HIV records (Including HIV test results) and sexually transmissible diseases

☐ Alcohol and substance abuse diagnosis and treatment records

☐ Psychotherapy records

☐ Not Applicable

May we discuss the above information with your Primary Care Physician ☐ Yes ☐ No

If so, please list the name of your Primary Care Physician: _____

Name(s) of other people authorized to obtain the above-mentioned information.
(E.g. Physician (other than your primary care physician), family members, and other specified person/persons)

Name: _____ Relationship: _____ Tel: _____
Name: _____ Relationship: _____ Tel: _____
Name: _____ Relationship: _____ Tel: _____
Name: _____ Relationship: _____ Tel: _____

Contact Information:

***Please list the **BEST** phone number that our office may contact you regarding appointment reminders and all other medical correspondence: _____

May we leave a detailed message on your answering machine or voicemail? ☐ Yes ☐ No

I approve being contacted about **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of Frisco Family ENT
☐ Yes ☐ No

In signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize, that you hold harmless the Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Patient or Representative: _____ **Relationship:** _____

Office Witness: _____ **Date:** _____