Name:
DOB:
Chart:
Age:
Date:

Ō·tō·laryn·gol'ō·gy Associates
ENT & Face, Head & Neck Plastic Surgery
www.otolaryn.com

OA Physician: _____

Contact Information for Protected Health Information

I, _____ (patient's name) DOB: _____

request that the following methods be adhered to for the disclosure of my Protected Health Information (Protected Health Information would include your name, diagnoses, test results, dates of service as described in the Notice of Privacy Practices).

Please check any or all of the three options that apply:

Option A:

☐ OA may disclose information by telephone to people designated below. **This document does not allow the people listed below to receive medical records. For OA to allow non patients to receive medical records, a release of information form must be signed by the patient or their power of attorney.**

Name	Phone Number	Relationship

Option B:

☐ You may leave Protected Health Information on my answering machine/voicemail at this phone number: (_____) _____

Option C:

☐ Other _____

Document is good for one year from date signed.

_____ _____
Patient's Printed Name Social Security Number

_____ _____
Patient's Signature (or Guardian if a minor) Date

_____ _____
Witness (optional) Date