FREEHOLD EAR NOSE & THROAT ASSOCIATES, P.A.
Otolaryngology | Face To Face: Plastic & Cosmetic Surgery

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HIPPA MEDICAL RELEASE REQUEST

All medical records are confidential. Protecting your privacy is very important to us; therefore, according to federal regulations, we may not discuss or release information to anyone other than you unless we are authorized to do so by you on the form below. We want to make sure you receive the information that is necessary to provide you with quality care and service.

Patient Name: _____ Date of Birth: _____

I give the office permission to contact me by (circle all that apply).

Call my: home / work / cell

Leave message on my: answering machine / cell phone

Send emails: _____

If you want to give us the authority to discuss medical information with someone other than yourself, please write their name, phone number, and relationship to you below (i.e. spouse, child, friend, etc.) This will also be who we contact in case of an emergency. If the person is a minor, please list his/her parents or legal guardians names below.

_____

_____

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ACKNOWLEGGEMENT OF RECEIPT OF PRIVACY NOTICE

Our practice is dedicated to maintaining the privacy of your confidential, protected health information (PHI). In conducting our business, we create records regarding your health status and the healthcare and services you receive in this office.

Our notice of Privacy Practices is hanging in the office and a copy is available upon request for you to view at any time. We are required by law to give you this notice. It will tell you how the practice is authorized to use or disclose your health information, and it explains your rights and obligations regarding the use and disclosure of that information.
By signing below, you acknowledge that you have read about our Notice of Privacy Practices.

Patient or Personal Representative _____ Date: _____

Print name if signature is on behalf of patient _____ Relationship: _____