CONFIDENTIAL COMMUNICATIONS

Patient Name:_____ Date of Birth: _____ MRN: _____

This form helps us understand how you want us to communicate with you, or others, about your medical care. You can choose what modes of communication you would like us to use and who we can share information with. We may need to communicate test results, prescription information or respond to a message you left with our office.

By completing this form, you understand the following:

- This form gives us permission to communicate with you in the manner that you choose. This form also authorizes us to discuss your health care with the individuals listed on this form.
- You can change your decisions on this form at any time by completing a new form. We cannot change information on this form over the phone or by fax. All changes and updates must be made in person at our office.
- If you give us permission to communicate your health information to someone else, you understand that this could include any information in your medical record including test results, medications, billing, diagnoses, procedures, etc.
- You have received a copy of our Notice of Privacy Practices and understand other ways Plattsburgh Otolaryngology–Head and Neck Surgery, PLLC (Plattsburgh ENT) can use or disclose your health information not otherwise listed on this form.
- This form permits verbal communication only. This form does not allow the individuals listed below to obtain copies of your medical records.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussions are permitted by law.

Please tell us how you would like us to communicate information to you by checking all the boxes that apply:

☐ You may contact me by telephone/text/voice mail: ☐ Cell ☐ Home _____

☐ You may contact me by e-mail. E-mail address: _____

Name and Phone Number	Relationship to Patient	Address

This authorization is valid for 12 months from the date of signature. I understand that I may revoke this consent in writing at any time, however, any use of disclosure that occurred prior to the date I revoked this consent is not affected.

_____ _____

Patient Signature or Guardian/ Legal Representative Date

_____ _____

Patient Printed Name or Guardian/Legal Representative Reason patient unable to sign

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