Adult and Pediatric- ENT
Head *and Neck Surgery,*
Voice and Swallowing,
Hearing and Balance,
Allergy

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Patient Contact Information Restriction

The HIPAA privacy rule gives you the right to request a restriction on uses and disclosures of your Protected Health Information.

I wish to be contacted in the following manner (**please check all that apply**):

- □ **Home Phone** (   ) _______- ___________
  - □ Okay to leave message with detailed information
  - □ Leave message with callback number only
- □ **Cell Phone** (   ) _______- ___________
  - □ Okay to leave message with detailed information
  - □ Leave message with callback number only

□ I hereby consent to the release of my medical information to the people listed below. This authorization will be in effect until I change it.

□ I hereby decline the release of my medical information to anybody. This authorization will be in effect until I change it.

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

______________________ ______________
Signature of Patient or Patients Representative **Date**

______________________ ______________
Print Patient's Name **Date of Birth**

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