TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.

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I have received a copy of the Patient Privacy Notice (Form HPPN1-2) from Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. Listed below are the individuals that I give permission to Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. to review or discuss my medical/financial issues. My emergency contact is given below.

I understand that for this medical practice to communicate with anyone regarding my medical files or financial account I must list them on this form. I also understand that if the patient is under 18, the parents must be listed on this form.

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Patient's Name Date of Birth

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•Name: ______________________________DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: _____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ______________________________DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: _____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ______________________________DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: _____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer.

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Patient Signature (if under 18, the parent or legal guardian's signature is required)

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INTERNAL USE ONLY: ________________________________ _______________________

Employee Signature Date Names Entered