

Consent for the Use of Disclosure of Protected Health Information

Kentucky Ear, Nose and Throat abides by the Health Information Portability and Accountability Act. As part of this Act, individuals over the age of 18 are required to name individuals they grant permission to receive personal health information. Please name those individuals below who we can speak to regarding your care received at Kentucky Ear, Nose and Throat. By default, if you do not list anyone we will not discuss your care. Your list does not need to include other health care providers or insurance companies, as they are or may potentially be involved in your care. We have found that naming family members allows us to relay important messages when you are unavailable and allows us to streamline your care. You are under no obligation to write any names on the lines below nor will this impact the care you will receive.

I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information:
Chemical Dependency, Substance Abuse, Drugs, Alcohol Abuse, Sexually Transmitted Diseases.

Patient's Printed Name

Patient's Social Security Number

Patient's Signature

Date

Please PRINT the names of the person(s) you allow us released information to:

Name

relationship to patient

Name

relationship to patient

Name

relationship to patient

Name

relationship to patient