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Midwest Hearing Aid and Sinus Center, LLC

Method of Disclosure and Permission to disclose Information to Those Involved in My Care

In general, the HIPPA privacy rules give the individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to individual's home.

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

Home phone _____ Written communication YES NO

Cell phone_____ OK to mail to home address YES NO

Leave detailed message at Home or Cell YES NO Other contact info_____

Work Number _____ Work Number detailed message YES NO

Enter your email to learn about upcoming new or events: _____

Permission to Disclose Information to Those Involved in my Care (check all that apply):
I hereby allow Midwest Ear Nose & Throat P.A., to disclose the following Protected Health Information to the following people because they are involved with my health care or payment:

_____Appointment times & dates _____Test results _____Other Health Information

_____Tests that have been received _____Billing Account Information

Relationship	**Contact #**
Spouse _____	_____
Mother _____	_____
Father _____	_____
Step Mother _____	_____
Step Father _____	_____
Friend _____	_____
Child _____	_____
Other _____	_____

_____ _____
Patient Signature Signature Patient Representative/Relationship

_____ _____
Print Patient Name Date

Annual Update ___/___; ___/___; ___/___; ___/___