fort worth ent
EAR NOSE & THROAT

Authorization and Consent Forms

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our Privacy Officer for Fort Worth ENT.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care options. We are required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to required federal and state reporting agencies. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your consent.

In the event a family member or caregiver attends my office visit and remains in the exam room at the time of my evaluation and/or treatment, I give Fort Worth ENT and its physician or employees my permission to discuss freely my condition, treatment, or diagnosis.

May we call you and/or leave a message on the numbers listed below?

Home Phone _____ May we leave a message Yes/No (please circle one)

Work Phone _____ May we leave a message Yes/No (please circle one)

Cell Phone _____ May we leave a message Yes/No (please circle one)

May we mail healthcare information to your home?

Any and all medical information can be released to the following:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Patient Name/DOB _____ Guardian Name _____

Patient or Guardian Signature _____ Date _____