

Ear, Nose & Throat Associates of Manatee, PA
&
Manatee Hearing & Speech Center, Inc
Collectively known and referred to as The Practice

PRIVACY AUTHORIZATION & VERIFICATION

Please **answer** and **completely** fill out the following questions to help us protect your privacy:

(1.) Is it okay to leave a detailed message on your answering machine? If there is not an answering machine, may we leave a message with whoever answers the phone. **YES / NO**
If the answer is **NO**, please let us know how you wish to be notified by our office:

(2.) Is it okay to release information to anyone other than yourself? **YES / NO**
If the answer is **YES**, please list each person.

PLEASE LIST BOTH PARENTS, IF THE PATIENT IS A MINOR:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

(REMINDER, WE WILL NOT **RELEASE INFORMATION** OR **SPEAK** TO ANYONE NOT LISTED)

(3.) Is it okay to release information to any medical professional participating in your care? **YES \ NO**

This is to verify that I have read and understand the above information.
By signing this statement I am giving The Practice and the staff's consent to release my personal information as described above.

Signature: _____

I also acknowledge that I have received a copy of the **Practice Privacy Policy** and I have been given an opportunity to read it and ask questions (**Brochure**).

Signature: _____

Date _____ **Chart #** _____