PROLIANCE SURGEONS®

PUGET SOUND EAR, NOSE AND THROAT

Patient Name: _____ DOB: ___/___/____
PRINTED NAME

1- HIPAA Form

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

Signature of Patient or Guardian: _____ Date: _____ Time: _____

Printed Name _____

2 - Emergency Contact

In case of emergency, I authorize PSENT to disclose information and/or review my care with:

Name	Phone Number	Relationship

3 - Authorization To Leave Personal Health Information By Alternate Means

(Please check all that apply)

- ☐ May leave detailed message on cell phone #_____
- ☐ May leave detailed message on voicemail at home # _____
- ☐ May leave detailed message at different location #_____
- ☐ May leave detailed message on voicemail at work #_____
- ☐ May leave information with spouse (name)_____
- ☐ May leave information with other family member (name)_____
- ☐ May send detailed email message by email to _____

**With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____

Patient or legally authorized individual signature Date

4 - AUTHORIZATION FOR THE TREATMENT OF A MINOR

I AUTHORIZE PROLIANCE SURGEONS INC. (Puget Sound Ear, Nose & Throat Center) TO TREAT THE MINOR PATIENT NAMED ABOVE.

SIGNATURE: _____ *DATE:* _____