OHIO VALLEY
EAR, NOSE & THROAT

HIPAA Communication

Patient Name: _____ Birthdate: _____

Due to the changing regulations and restrictions that are being implemented by HIPAA, it is necessary to ask you the following questions. These regulations and restrictions are for your protection and this information will help us better serve you, while safeguarding your Personal Health Information (PHI). We may ask you and your authorized family members or other persons certain questions to verify identification. Thank you for your assistance in helping us protect your PHI.

1. **Please list the family members or other persons whom we may inform** about your general medical health, release sample medications, prescriptions, lab results, other private health information, or contact in case of emergency. Some of this information may include your diagnosis(es), appointment information, plan of treatment, billing information and medication use. Please list the person(s) full name, relationship, and phone number if possible. **You are not required to list anyone to receive information**.

Name	Relationship	Phone #

2. Do we have your permission to leave confidential messages, such as appointment reminders, on your voicemail? This is not inclusive of all the confidential information that may be involved.
   ☐ Yes ☐ No
   If your answer is NO, may we call your home simply stating to "please call our office?"
   ☐ Yes ☐ No
3. Please indicate if all correspondence from our office, other than billing statements, should be sent to you in a **CONFIDENTIAL** sealed envelope.
   ☐ Yes ☐ No
4. Please list where you would want your billing statements sent if **other than** your home address. Please include the street address, apartment or lot number, city, state, zip, and persons name and relationship to patient, if applicable.

   _____

   _____

I understand that the information used or disclosed pursuant to this authorization constitutes Protected Health Information ("PHI") and that such PHI will exist forever in a recorded, printed, or electronic medium or any other medium that may develop over time. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state laws.

I understand that this authorization may be revoked at any time in writing to Ohio Valley Medical Group DBA Ohio Valley Ear, Nose & Throat ("OVENT") except to the extent that action has been taken in reliance upon it. Further, I understand that this authorization will remain in effect unless specifically revoked by me. If this authorization is not revoked, it will expire ten years from the date below. I release OVENT and its affiliated entities, representatives, agents, and employees from any and all claims, liabilities, or damages that I, my assignees, heirs, distributes, guardians, next of kin, children, spouse, or legal representatives have, or may have in the future, that may arise from the use of Materials.

I have received a copy of the Notice of Privacy Practices for this office. I understand as a patient, I have rights and have been informed.

Signature of Patient or Guardian _____ Date _____

Ear, Nose & Throat

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