

Coastal Ear, Nose, and Throat
Coastal Hearing and Balance Center
1520 Highway 138
Wall, NJ 07719

I. Acknowledgement of CENT's Notice of HIPAA Privacy:

Name of Patient Date of Birth Signature of parent/guardian Date

II. Designation of certain relatives, close friends, and other caregivers:

I agree that Coastal Ear, Nose and throat may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with my health care. In that case, CENT will disclose only information that is directly relevant to the person's involvement with my health care.

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

Home telephone number: _____
 O.K. to leave message with detailed information
 Leave message with call back number only
 O.K. to mail to my home address as listed on patient information sheet
 O.K. to fax to this number _____
 O.K. to e-mail at this address _____

Work telephone number: _____
 O.K. to leave message with call back number
 O.K. to leave detailed message

I designate the following persons listed below as persons involved with my healthcare, for the purpose of the practice making the limited disclosures as described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time.

*****PLEASE NOTE*** WE WILL NOT RELEASE INFORMATION TO ANYONE WHO IS NOT LISTED ON THIS FORM**

Print Name: _____ Last four digits of SS# _____
(required) initial here
Print Name: _____ Last four digits of SS # _____
(required) initial here
Print Name: _____ Last four digits of SS # _____
(required) initial here

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, patient health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep record of protected health information disclosures. Uses and disclosures for treatment, payment, and health care operations may be permitted without prior consent.

Signature of patient/parent or guardian

Date