CLEVELAND
SINUS INSTITUTE

Hillcrest Hospital
Atrium Medical Offices
6770 Mayfield Road,
Suite 441
Mayfield Heights, OH 44124

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

☐ **Home telephone**_____

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

☐ **Written communication**

☐ Okay to mail to my home address

☐ Okay to mail to my work/office address

☐ **Work telephone**_____

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

☐ Okay to fax to this number_____

☐ **Other: List family members if any:**

_____

_____

_____

Patients name (please print)

_____
Birth date

Signature (patient/parent/guardian)

Date

THE PATIENT IS RESPONSIBLE FOR PROVIDING ANY NECESSARY CHANGES TO THIS FORM.

Authorization and Consent to Use and Disclose Medical Information

The Notice of privacy Practices of Northcoast Ear, Nose, and Throat INC. provides information about how we may use and disclose confidential information about you. Please read our notice before signing this consent. The terms of our notice may change from time to time. If we change our Notice, you may obtain a revised copy during your next visit.

By signing this Authorization, you agree to let us use and disclose confidential medical information about you for treatment, payment and health care operations. This includes information about your physical and mental illness, substance abuse or HIV /AIDS, if applicable. You are also consenting to the release of medical information about you to any insurer, third party payer, the Social Security Administration, or any agents or consultants who help this office obtain payment for your treatment as well as other health care operations.

Date_____ Patient Signature _____