Shastaent**Specialists**
Reddingsinus**Center**

George H. Domb, MD
2125 Court Street
Redding, CA 96001
Phone: 530-242-5600
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Patient Preference Regarding Communication of Health Information: Consent to Disclose

I hereby give permission to ***Shasta ENT Specialists*** to disclose and discuss any information related to my medical condition(s) to/with the following member(s), other relative(s) and/or close personal friend(s):

Name: ____ Phone: ________________________ Relationship: ________________

Name: ____ Phone: ________________________ Relationship: ________________

☐ NO — I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

I wish to be contacted in the following manner:

Home Phone: ____________________________________ Cell Phone: ____

Work Phone: ____________________________________ Email: ____

☐ Ok to leave Message with detailed information

☐ Leave Message with call-back number only

☐ Written communication: letter / email: ____

☐ Ok to Fax to this number: ________________________________

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient/Responsible Party Signature: ____ Date: ________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES:

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Shasta ENT Specialists is furnishing you with the attached notice, which provides information about how Shasta ENT Specialists and it's physician(s) may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

____ ______________________________

Patient or Legal Representative Signature: Date:

Reviewed by Employee: __________