

Ear, Nose & Throat Associates of Manatee, PA
&
Manatee Hearing & Speech Center, Inc
Collectively known and referred to as The Practice

PRIVACY AUTHORIZATION & VERIFICATION

Please answer the following questions to help us protect your privacy:

Is it okay to leave a detailed message on your answering machine? YES / NO

Is it okay to release information to anyone other than you? YES / NO

If answer is YES, please list each person:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

(REMINDER, WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED)

This is to verify that I have read and understand the above information. By signing this statement I am giving The Practice and its staff consent to release my personal information as described above.

Signature:

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRACTICE PRIVACY POLICY AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ IT AND ASK QUESTIONS (Brochure)

Signature:

Date: _____

Chart # _____