Ear, Nose, & Throat care for your family

Georgetown ENT

a professional association

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Patient Name ______________________ Date of Birth ______________________

Release of Protected Health Information to Family and Friends

I grant permission for Scott W. Franklin, MD, Georgetown ENT, Georgetown Better Hearing Center and Georgetown Allergy and Sinus Center (collectively referred to as the GENT Group) and the representatives of the GENT Group to disclose my protected health information to the individual(s) listed below. The purpose of this disclosure is to authorize the GENT Group and its representatives the opportunity to share relevant information about healthcare or discuss financial information for payment on a patient's account with family and friends.

Are there any specific family members or friends that you would like our staff to disclose medical, appointment, and/or financial information to on your behalf? If the patient is a minor, please include the family members or friends with whom our staff should disclose protected health information to on behalf of the minor child. ***OUR OFFICE WILL NOT TALK TO ANY FAMILY MEMBERS OR FRIENDS THAT ARE NOT ON THIS FORM, INCLUDING A SPOUSE, PARENT OR CHILDREN!***

COMPLETE SECTION A OR B:

A. Release my protected health information to the following person(s)/entity:

Name: ______________________ Phone: ______________________ Relationship: ______________________
Name: ______________________ Phone: ______________________ Relationship: ______________________
Name: ______________________ Phone: ______________________ Relationship: ______________________

The information you may release subject to this authorization is the following:

Appointment date/time ☐ Yes ☐ No   Explanation of diagnosis and/or procedures ☐ Yes ☐ No

Lab reports ☐ Yes ☐ No   Billing information ☐ Yes ☐ No

------ OR ------

B. ______ I do not want any of my information shared with family or friends

Initial

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to the GENT Group.

______________________ ______________________ ______________________

Signature of Patient or Personal Representative   Relationship to Patient   Date