PIEDMONT EAR NOSE & THROAT ASSOCIATES, PA

PATIENT MEDICAL RECORD # _____
(for office use only)

COMMUNICATION FORM

So that we may serve you more efficiently, you have the option of providing us with a list of family members/friends with whom we may discuss your or your child's health information. You are ***not*** required to provide a list or to sign this form. **Note: Doctors directly involved in your or your child's medical treatment do not need to be listed.**

Adults (18 and older)

☐ Yes, I give permission for Piedmont Ear, Nose & Throat Associates to share my health information with the people listed below who are involved in my medical care.

☐ No, my health information is not to be released to anyone.

For Children (Less than 18 years of age)

☐ Yes, I give permission for Piedmont Ear, Nose & Throat Associates to share my child's health information with the people listed below who are involved in my child's medical care.

☐ No, my child's health information is not to be released to anyone.

☐ Yes, I give Piedmont Ear, Nose & Throat Associates permission for the people listed below to accompany my child at his/her doctor visit.

NAME	RELATIONSHIP	CONTACT NUMBER

If there are changes, at any time, to the list above, I understand that it is my responsibility to notify PENTA in writing. _____ (Initials)

☐ I give Piedmont Ear, Nose & Throat Associates permission to leave messages regarding lab/test results on my answering machine/Voice mail.

☐ I **do not** give Piedmont Ear, Nose & Throat Associates permission to leave messages regarding lab/test results on my answering machine/Voice mail.

Print Patient Name	Patient/Parent/Patient Representative Signature	Date
Patient Date of Birth	**Witness**	**Date**