Wichita Ear Clinic
Health Information Management Consent Form

New Patient Consent and to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

Patient Name: _____DOB: _____

HOW MAY WE CONTACT YOU:

Please list all forms of communication:

- ☐ Home Phone:(_____) - _____ - _____
- ☐ Work Phone: (_____) - _____ - _____
- ☐ Cell Phone: (_____) - _____ - _____
- ☐ Other _____
- ☐ Email _____

If you are not available may we leave a voice message?

- ☐ NO, Do not leave a voice message
- ☐ YES, Please leave a voice message

Who may we communicate with?

- ☐ Self Only
- ☐ Spouse (Name) _____ Phone: _____
- ☐ Child (Name) _____ Phone: _____
- ☐ Parents (Name) _____ Phone: _____
- ☐ Other (Name) _____ Phone: _____

(Relationship to Patient)_____

What protected health information may we disclose?

- ☐ Any Information
- ☐ Test Results
- ☐ Appointment Information
- ☐ Billing Information
- ☐ Other _____

_____

Patient or legal representative signature Date