PLEASE PRINT LEGIBLY

Mountain Home ENT & Allergy

Patient Name: _____ Date of Birth:_____

It may be necessary for the office to leave a message for you regarding medical information such as test results, prescriptions, billing or account information or other health care issues.

Can we leave a message on your:

Home Phone: ☐ **Yes** ☐ **No** **Number:** _____

Work Phone: ☐ **Yes** ☐ **No** **Number:** _____

Cell Phone: ☐ **Yes** ☐ **No** **Number:** _____

Please list every family member or friend who is authorized to speak with us about your health care issues. This includes spouses, children or parents.

Remember that if anyone calls us with a question, we will not be able to speak with them unless they are listed here.

Name	Relationship	Phone Number

This will remain in effect until it is revoked in writing.

Patient Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We are required by law to maintain the privacy and provide individuals with the notice of our legal duties and privacy practices with respect to protected health information (PHI). You may request a complete copy of our Notice of Privacy Practices or access it via our website at www.mhentallergy.com.

Patient's Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____

If not patient, state relationship: _____