

**PATIENT INFORMATION**

Name (Last, First, Middle Initial): \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is your mailing address the same as your street address? YES NO

If your answer was no, please indicate your mailing address:

Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status: MARRIED SINGLE OTHER

Employer: \_\_\_\_\_ Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Occupation: \_\_\_\_\_ Industry: \_\_\_\_\_

Are you the Guarantor/Responsible Party? YES or NO

**IF YOUR ANSWER WAS NO, PLEASE PROVIDE:**

Guarantor Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last, First, Middle Initial)

Relationship to Patient: \_\_\_\_\_ Address: \_\_\_\_\_

**COMMUNICATION WAIVER**

I understand that as a part of my healthcare, Milton Hall Surgical Associate, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) may need to contact me in order to remind me of an appointment, provide test results, give instruction, or provide other information. I authorize the above to contact me in the following ways:

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Fax Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ E-mail Address: \_\_\_\_\_

Do you give the ENT Institute permission to text your mobile device? YES or NO

Do you give the ENT Institute permission to leave voicemail to the phone number you provided above?  
YES or NO

Do you consent to receive automated phone calls from our practice on your mobile device? YES or NO

Preferred Contact Method: \_\_\_\_\_ Primary Language: \_\_\_\_\_

I give permission for Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) to discuss my information with the following person(s):

\_\_\_\_\_  
Relationship: \_\_\_\_\_

\_\_\_\_\_  
Relationship: \_\_\_\_\_

I understand that Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) has a secure server & encryption for e-mail communication. I understand that Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this communication waiver at any time. Any revocation or change will not apply to past communications.



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**PATIENT INFORMATION**

Patient/Parent/Guardian/ Signature \_\_\_\_\_ Date: \_\_\_\_\_

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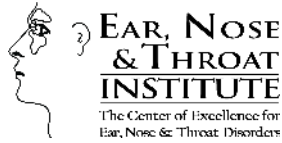


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**PATIENT INFORMATION**





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**PATIENT INFORMATION**

NAME:

DOB:

**NOSE:**

| SYMPTOMS              | ONSET DATE | FREQUENCY | LOCATION |
|-----------------------|------------|-----------|----------|
| FACIAL PAIN/HEADACHES |            |           |          |
| POST-NASAL DRAINAGE   |            |           |          |
| BLEEDING              |            |           |          |
| CONGESTION            |            |           |          |
| NASAL DRAINAGE        |            |           |          |
| LOW ENERGY            |            |           |          |
| FEVER/FEVERISH        |            |           |          |
| NAUSEA                |            |           |          |

OTHER SYMPTOMS/ ADDITIONAL COMMENTS:

**EAR:**

| SYMPTOMS                       | LEFT | RIGHT | BOTH | PLEASE DESCRIBE |
|--------------------------------|------|-------|------|-----------------|
| PAIN                           |      |       |      |                 |
| DRAINAGE                       |      |       |      |                 |
| SENSATION OF THE ROOM SPINNING |      |       |      |                 |
| HEARING LOSS                   |      |       |      |                 |
| RINGING NOISE                  |      |       |      |                 |

OTHER SYMPTOMS/ ADDITIONAL COMMENTS:

**THROAT:**

| SYMPTOMS                              | ONSET DATE | FREQUENCY | LOCATION |
|---------------------------------------|------------|-----------|----------|
| SORENESS                              |            |           |          |
| SWOLLEN NODES                         |            |           |          |
| SWOLLEN GLANDS                        |            |           |          |
| HOARSENESS                            |            |           |          |
| DIFFICULTY SWALLOWING                 |            |           |          |
| COUGHING                              |            |           |          |
| SENSATION OF SOMETHING IN YOUR THROAT |            |           |          |
| PAIN                                  |            |           |          |
| SNORING                               |            |           |          |
| SHORTNESS OF BREATH/WHEEZING          |            |           |          |
| HOARSENESS                            |            |           |          |

OTHER SYMPTOMS/ ADDITIONAL COMMENTS:

WHAT TREATMENT HAVE YOU HAD FOR THESE SYMPTOMS OVER THE PAST YEAR?



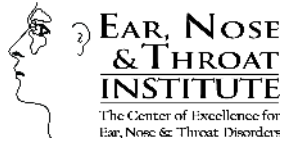


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**PATIENT INFORMATION**





**PATIENT INFORMATION**

NAME:

DOB:

**PATIENT HEALTH HISTORY**

**SURGERIES**

| YEAR | REASON | HOSPITAL |
|------|--------|----------|
|      |        |          |
|      |        |          |
|      |        |          |
|      |        |          |
|      |        |          |

**OTHER HOSPITALIZATIONS**

| YEAR | REASON | HOSPITAL |
|------|--------|----------|
|      |        |          |
|      |        |          |
|      |        |          |
|      |        |          |

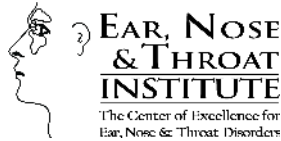
**PLEASE LIST ALL CURRENT MEDICATIONS, DOSES AND FREQUENCY (PRESCRIPTION & NON-PRESCRIPTION):**

| MEDICATION | DOSE | FREQUENCY |
|------------|------|-----------|
|            |      |           |
|            |      |           |
|            |      |           |
|            |      |           |
|            |      |           |
|            |      |           |

**MEDICATION ALLERGIES:**

| MEDICATION | REACTION |
|------------|----------|
|            |          |
|            |          |
|            |          |

|                 |  |   |  |  |
|-----------------|--|---|--|--|
| <b>CAFFEINE</b> | <input type="checkbox"/> NONE <input type="checkbox"/> COFFEE <input type="checkbox"/> TEA <input type="checkbox"/> COLA |   |  |  |
|                 | # OF CUPS PER DAY _____  |   |  |  |
| <b>ALCOHOL</b>  | DO YOU DRINK ALCOHOL?  |   | Yes      No                                |  |
|                 | FREQUENCY: _____ DRINKS PER DAY/WEEK   |   |  |  |
| <b>TOBACCO</b>  | DO YOU USE TOBACCO   |   | Yes      No                                |  |
|                 | <input type="checkbox"/> CIGARETTES- PACK(S)/DAY _____   | <input type="checkbox"/> CHEW- #/DAY _____  | <input type="checkbox"/> PIPE- #/DAY _____ | <input type="checkbox"/> CIGARS- #/DAY _____ |
|                 | <input type="checkbox"/> # OF YEARS _____  | <input type="checkbox"/> OR YEAR QUIT _____ |  |  |
| <b>DRUGS</b>    | DO YOU CURRENTLY USE RECREATIONAL STREET DRUGS?  |   | Yes      No                                |  |
|                 | HAVE YOU EVER GIVEN YOURSELF STREET DRUGS WITH A NEEDLE?   |   | Yes      No                                |  |
| <b>OTHER</b>    | DO YOU TRAVEL INTERNATIONALLY?      FREQUENCY: _____   |   | Yes      No                                |  |
|                 | ARE YOU EXPOSED TO SECONDHAND SMOKE?   |   | Yes      No                                |  |



**PATIENT INFORMATION**

|  |     |    |
|--|-----|----|
| DO YOU HAVE PETS IN YOUR HOME?                           | Yes | No |
| ARE YOU EXPOSED TO A CHILDCARE SETTING? FREQUENCY: _____ | Yes | No |

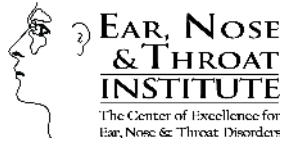
**CURRENT OR HISTORICAL PATIENT HEALTH HISTORY**

**PLEASE MARK THOSE THAT APPLY:**

|                          |    |     |                         |    |     |
|--------------------------|----|-----|-------------------------|----|-----|
| ACID REFLUX/GERD         | NO | YES | THYROID PROBLEMS        | NO | YES |
| ADD/ADHD                 | NO | YES | HYPERTHYROIDISM         | NO | YES |
| AIDS/HIV                 | NO | YES | HYPOTHYROIDISM          | NO | YES |
| ALLERGIES/HAYFEVER       | NO | YES | HEAD INJURY/CONCUSSION  | NO | YES |
| ANEMIA                   | NO | YES | HEADACHES               | NO | YES |
| ANESTHESIA COMPLICATIONS | NO | YES | HEARING LOSS            | NO | YES |
| ARTHRITIS                | NO | YES | IMMUNE SYSTEM DISORDER  | NO | YES |
| ASTHMA                   | NO | YES | KIDNEY DISEASE          | NO | YES |
| AUTISM DISORDER          | NO | YES | LIVER DISEASE           | NO | YES |
| BASAL CELL CARCINOMA     | NO | YES | MELANOMA                | NO | YES |
| BEDWETTING               | NO | YES | MIGRAINES               | NO | YES |
| BIRTH DEFECTS/DISEASE    | NO | YES | NASAL OR SINUS PROBLEMS | NO | YES |
| BLADDER/KIDNEY PROBLEM   | NO | YES | OBESITY                 | NO | YES |
| BLEEDING DISORDER        | NO | YES | NASAL POLYPS            | NO | YES |
| BLOOD CLOT               | NO | YES | OSTEOPOPOROSIS          | NO | YES |
| BLOOD DISEASE            | NO | YES | OTHER SKIN CONDITIONS   | NO | YES |
| BRONCHITIS               | NO | YES | SKIN CANCER             | NO | YES |
| CANCER                   | NO | YES | PACEMAKER               | NO | YES |
| CHICKEN POX              | NO | YES | PCOS                    | NO | YES |
| CHRONIC EAR INFECTIONS   | NO | YES | PITUITARY DISORDER      | NO | YES |
| CONGENITAL ANOMALIES     | NO | YES | PNEUMONIA               | NO | YES |
| CONSTIPATION             | NO | YES | PULMONARY EMBOLISM      | NO | YES |
| COPD                     | NO | YES | RHINITIS                | NO | YES |
| CORONARY ARTERY DISEASE  | NO | YES | SEIZURES/EPILEPSY       | NO | YES |
| DEPRESSION               | NO | YES | FIBROMYALGIA            | NO | YES |
| DEVELOPMENTAL DELAY      | NO | YES | FOOD ALLERGY            | NO | YES |
| BEHAVIORAL DISORDERS     | NO | YES | SLEEP DISORDER          | NO | YES |
| DIABETES                 | NO | YES | SPEECH DELAY            | NO | YES |
| DIFFICULTY SWALLOWING    | NO | YES | SQUAMOUS CELL CARCINOMA | NO | YES |
| ECZEMA                   | NO | YES | STROKE                  | NO | YES |
| EMPHYSEMA                | NO | YES | TONSIL INFECTIONS       | NO | YES |
| GLACOMA                  | NO | YES | TUBERCULOSIS            | NO | YES |
| GOUT                     | NO | YES | VISION OR EYE PROBLEMS  | NO | YES |
| HEART ATTACK             | NO | YES | HIGH CHOLESTEROL        | NO | YES |
| HEART DISEASE            | NO | YES | HIVES                   | NO | YES |
| HEART CONDITIONS         | NO | YES | HYPERLIPIDEMIA          | NO | YES |
| HEPATITIS                | NO | YES | HYPERTENSION            | NO | YES |

**IF YOU ANSWERED YES TO ANY OF THE ITEMS ABOVE PLEASE EXPLAIN:**





**PATIENT INFORMATION**

**FAMILY HISTORY**

| <b>EVENT</b>               | <b>RELATION</b> | <b>NOTE</b> |
|----------------------------|-----------------|-------------|
| ALLERGY                    |                 |             |
| ANEMIA                     |                 |             |
| ASTHMA                     |                 |             |
| BLOOD COAGULATION DISORDER |                 |             |
| CORONARY ARTERIOSCLEROSIS  |                 |             |
| DEVELOPMENTAL DISORDER     |                 |             |
| DIABETES                   |                 |             |
| ENDOCRINE DISORDER         |                 |             |
| THYROID GLAND DISORDER     |                 |             |
| ENVIRONMENTAL ALLERGY      |                 |             |
| CANCER                     |                 |             |
| HEARING LOSS               |                 |             |
| HEART DISEASE              |                 |             |
| HYPERTENSION               |                 |             |
| IMMUNODEFICIENCY DISORDER  |                 |             |
| MENTAL DISORDER            |                 |             |
| HEART ATTACK               |                 |             |
| MENIERE'S DISEASE          |                 |             |
| OTOSCLEROSIS               |                 |             |
| SEIZURE                    |                 |             |
| SLEEP APNEA                |                 |             |
| TUBERCULOSIS               |                 |             |

\_\_\_\_\_  
 PATIENT/AUTHORIZED GUARDIAN SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 DATE







The purpose of this form is to obtain your consent to participate in a telemedicine consultation with our specialist.

- 1) **Purpose and Benefits:** The purpose of the telemedicine platform is to allow patients, new and established, access to our providers for healthcare outside of normal office hours with the additional benefit of cost effective care.
- 2) **Nature of Telemedicine Consultation:** During the telemedicine consultation:
  - a) Details of you and/or your child's medical history, examinations, radiological films, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
  - b) Physical examination of you or your child may take place.
  - c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
  - d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
- 3) **Medical Information and Records:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.
- 4) **Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Georgia State law apply to information disclosed during this telemedicine consultation.
- 5) **Risks and Consequences:** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Following the telemedicine consultation, your physician may recommend a visit to a Hospital in the Atlanta area for further evaluation.
- 6) **Rights:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the specialist in person if you travel to his or her location.
- 7) **Financial Agreement:** This telemedicine consultation will be paid for by you and **your insurance company will not be billed for this visit.**

\_\_\_\_ I authorize the ENT Institute to disclose my **full** medical record to my insurance carrier.

\_\_\_\_ I authorize the ENT Institute to disclose my medical record **without any self pay services** to my insurance carrier.

*I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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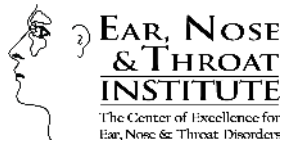
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**PATIENT INFORMATION**

Patient (or person authorized to give consent)

If signed by person other than patient, provide relationship to patient: \_\_\_\_\_





## PATIENT INFORMATION

### Authorization to Release Information

I hereby authorize Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) to furnish to my insurance carrier or to health care financing or its intermediaries or carrier, any information needed regarding my medical treatment. Regulations pertaining to Medicare assignments of benefits apply. I authorize an associate from Milton Hall Surgical Associates to act on my behalf, if necessary, to the insurance commissioner governing my insurance company.

### Financial Responsibility

**Insurance, Medicare, and Medicaid:** I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) for any and all medical/healthcare services, supplies, tests, treatment, and/or medications that have been or will be rendered or provided; as well as designating and appointing Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) my beneficiary under all health insurance or medical plans which I may have benefits under.

I understand that I am financially responsible for all services rendered including any charges or penalties made to Milton Hall Surgical Associate for any outside collection assistance. I realize that the physician is not responsible for any financial decisions of non-payment made by an insurance company contracted by the insured to assist in payment of medical services.

I also understand my insurance policy may not cover all services. I understand that it is my responsibility to understand my insurance policy and acknowledge that I am responsible for payment of any service not covered by my insurance plan. If a service provided by Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) is not covered by my insurance, I agree to pay for this service as an out-of-pocket expense. I understand that additional diagnostic evaluations may be performed based upon my symptoms and at provider expertise. These include, but are not limited to endoscopies, wax removal, etc. Due to insurance regulations, these additional diagnostic evaluations maybe processed according to my insurance benefits and may be applied towards my deductible and/or co-insurance, leaving me responsible for any out of pocket expense.

I understand that ENT Institute utilizes Chestatee Pathology, Diatherix, and Microgen Laboratories for specialized testing that Labcorp and Quest laboratories do not offer. Chestatee Pathology, Diatherix, and Microgen Laboratories may be considered “Out of Network” with my insurance carrier. Should my Provider order these specialized tests, I acknowledge that I may receive an invoice from Chestatee Pathology, Diatherix, or Microgen Laboratories.

I understand that copayment is due at time of service and I will not be seen if I do not pay my copay and my outstanding balance, or make mutually agreed upon payment arrangements for my balance. If I do not have insurance at time of service, I understand I will be considered a Self-Pay patient and full payment is due at the time of service.

I understand and acknowledge under Medicare law, I must pay the annual Medicare deductible for Part B services and a co-payment/co-insurance on claims for services that are submitted after meeting the deductible. A waiver form must be signed even if Medicare does not apply at this time. By signing the above clause, I am agreeing that if at any time after completing this form I become eligible for Medicare, I agree to pay according to the Medicare law.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, or to pursue any other remedies necessary in connection with the same.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent at the effective date of this document that it shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and enforceable as the original.

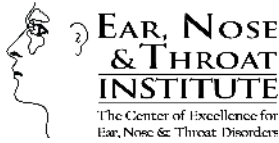
### Referral

I understand that I may require a referral by my policy contract from my primary physician before seeing a specialist. If I am required to have a referral for today’s visit, I understand that I will be financially responsible for all services rendered should I not have a referral.

### Appointment

I understand that it is my responsibility to cancel or reschedule an appointment 24 hours prior to the scheduled appointment and that if I fail to do so, I will be assessed a cancellation fee of \$75.00. I understand that this fee is not covered by my insurance plan. This charge also applies to sleep studies, ENG/VNG or audiology appointments.

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## PATIENT INFORMATION

### Signature

I understand that my initials signed to any documents will be sufficient for the use of my full signature.  
I understand that all signed documents become electronic format and allow a photocopy to be used in place of the original.

### Fees

**Medical Record:** I understand there is a charge for copying records to me, including disability and FMLA forms. The fee for copying records in paper form is 97 cents per page for the first 20 pages and 83 cents per page for page 21-100. Pages over 100 are charged at 66 cents per page. Cost of certification (notary) is up to \$9.70 per record. The fee for disability record is \$15, and FMLA forms are \$75. There is a fee for search and retrieval and direct administrative cost of \$25.88. Postage is charged separately and will be determined prior to payment. All fees will be due at the time of release of records/forms. (There will be no charge for records sent to another physician for continuation of care)

**Shipping:** Applicable shipping fees will be applied for any items shipped to any other location outside our practice.

**Interpreter:** If during my medical care I require the use of an interpreter, Milton Hall Surgical Associates will provide this service via a communications company of their choice at no additional charge to me. If I choose to bring an outside interpreter, I will be financially responsible for the cost.

**Collection:** I agree to reimburse the fees of any collection agency or attorney firm, which may charge based on a percentage of 28% maximum of the debt, and all costs and expenses, including reasonable attorneys' fees, which may occur in such collection efforts.

### Dispute Resolution

Any dispute that arises between me and The ENT Institute and/or its doctors (including any claims of medical malpractice) that have not been resolved through good faith discussions must be submitted to mediation with American Arbitration Association, and any disputes that are not resolved through the mediation, at the sole option of The ENT Institute, must be submitted to arbitration with American Arbitration Association. As The ENT Institute is engaged in interstate commerce, the Federal Arbitration Act applies.

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Patient Name (Please Print)

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Date of Birth

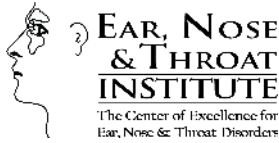
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Patient/Parent/Guardian Signature

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Date

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## PATIENT INFORMATION

### Notice of Privacy Practice Acknowledgement Statement and Release of Information Authorization

#### 1. Notice of Privacy Practice Acknowledgement Statement

I hereby acknowledge that I have been made aware that Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) has a Privacy Practice in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent revisions.

As a patient of Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”), I understand and acknowledge the following:

1. Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) has a notice of Privacy Practice in effect in their offices.
2. Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) has made this policy available to me for review, by placing a complete version in a binder that resides in the reception area and/or by placing a poster version of this policy in the reception area and a copy is also accessible via our website: [www.entinstitute.com](http://www.entinstitute.com).
3. Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) has made me aware, that as a patient I am entitled to a copy of the Notice of Privacy Practice (NPP) if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the Notice of Privacy Practice (NPP) implemented by Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) and have read and understand the acknowledgement form. If you desire a copy of the Notice of Privacy Practice, please request one at this time.

\_\_\_\_\_ **No, I do not want a copy but I acknowledge the Notice of Privacy Practice exists.**

\_\_\_\_\_ **Yes, I do want a copy of the Notice of Privacy Practice.**

#### 2. Release of Information Authorization

I hereby authorize Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute (“ENT Institute”) and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice’s Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

\_\_\_\_\_  
Patient name (Please Print)

\_\_\_\_\_  
Date of Birth



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The Center of Excellence for  
Ear, Nose & Throat Disorders

**PATIENT INFORMATION**

---

Patient/Parent/Guardian Signature

Date





**PATIENT INFORMATION**  
**REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**1. Introduction**

**Overview:** The Health Insurance Portability and Accountability Act (“HIPAA”) allows you to request that Milton Hall Surgical Associates d/b/a the Ear, Nose, and Throat Institute (“ENT Institute”) limit certain uses and disclosures of your protected health information (“PHI”). For example, you may request that we not share your PHI with a particular person.

The ENT Institute considers protecting your PHI very important. While the ENT Institute considers all restriction requests, in certain circumstances, the ENT Institute may be unable to limit how we use and/or disclose your PHI because it would harm our ability to provide quality services or because the disclosure of your PHI may be required by law.

**2. Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**3. Specific Restriction Requested**

Please state how you would like the ENT Institute to restrict the ways we use and/or disclose your PHI and the reason(s) for your request:

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**4. Patient/Authorized Representative Signature**

Authorized signature of individual or personal representative of individual for whom the restriction is being requested:

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Authorized Representative Signature Date

**Important: If legal documentation is not on file with the ENT Institute, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.**

\_\_\_\_\_  
Authorized Representative’s Name Mailing Street Address City State

\_\_\_\_\_  
Relationship to Patient and Authority to Act for Patient Phone Number Zip Code

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