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PATIENT COMMUNICATION CONSENT FORM

Patient Name _____ Date of Birth_____

Parent/Guardian Name_____

I agree to allow Massachusetts Ear, Nose and Throat Associates to contact me in the following methods regarding my private health information, treatment, appointment reminders and other notification regarding my care .

Home Phone _____Yes _____ No **Cell Phone** _____Yes _____ No

Text Messages _____Yes _____ No **Email** _____Yes _____ No

Patient Portal _____Yes _____ No

I also authorize Massachusetts Ear, Nose and Throat Associates to access my Pharmacy record electronically for an updated medication list.
_____Yes _____ No

CHECK ONE:

_____ I authorize _____ to receive information on my behalf via above communication and in the exam room with the provider. Relationship to patient (circle one):

Parent Child Spouse Grandparent Grandchild Guardian Other

OR

_____ I DO NOT authorize Mass ENT to give information on my behalf to any person other than myself. (This does not include other medical practices, insurance companies, or any other entity addressed in the Hipaa agreement)

CONSENT TO HEALTH INFORMATION EXCHANGE:

I consent to allow my provider to use Health Information Exchanges (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to other healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

_____ _____
Patient/Authorized signature Date

By my signature below I acknowledge that I have read and understand the **Guidelines to Patient Communication** and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that may impose.

_____ _____
Patient/Authorized signature Date