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