OTOLARYNGOLOGY ASSOCIATES, P.C.

RELEASE OF INFORMATION

I, the undersigned, authorize Otolaryngology Associates, PC (OA) to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by OA to the listed persons and thereby release OA and their staff from all legal responsibility that may arise from the act hereby authorized.

Authorized Person	Relationship to Patient	Phone Number
Authorized Person	Relationship to Patient	Phone Number

Signature of Patient / Responsible Party _____ Date _____

ASSIGNMENT OF BENEFITS

I, _____ (Please print your name) hereby authorize Otolaryngology Associates, PC (OA) to apply for benefits for covered services rendered by OA, and to request that the payments from Medicare, Medicaid, Blue Cross/Blue Shield and/or _____ (other insurance company) be made directly to OA if they choose to accept assignment, or to myself or to the party who accepts assignment.

I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim to Medicare, Medicaid, Blue Cross/Blue Shield and/ or _____ (other insurance as listed above).

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services provided to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (name of Medigap Carrier) any information needed to determine these benefits payable for related services.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

Subscriber or Policy Holder Signature	Insurance ID Number	Date

CONSENT TO THE OTOLARYNGOLOGY ASSOCIATES NOTICE OF PRIVACY PRACTICES (DATED MAY 1, 2015)

I, _____, consent to the use and disclosure of my Protected Health Information by Otolaryngology Associates, PC (OA) for treatment, payment and operations as allowed under the Health Insurance Portability and Accountability Act (HIPAA). The Notice of Privacy Practices describes the use and disclosure of my Protected Health Information that Otolaryngology Associates may undertake as well as other important information about my rights and control of my Protected Health Information.

I had the opportunity to read OA's summary of the Notice of Privacy Practices that is displayed in the office as well as the complete Notice of Privacy Practices that was available at their office and on their website. I was encouraged to read the Notice of Privacy Practices before deciding to sign this consent form.

I know that I can revoke this consent at any time by written notice to the Privacy Office at Otolaryngology Associates.

Signature of Patient _____ Date _____