ORL
ASSOCIATES
Wakstein & Holender
Ear • Nose • Throat • Facial Plastic Surgery

CONSENT FOR RELEASE OF INFORMATION

As a patient in our practice, from time to time we may need to communicate with you or with physicians involved in your care, when you are not in the office. To preserve your privacy, we would like you to indicate your preferred method for us to communicate information to you and ask your permission to communicate with your physicians.

In the event that no one is available to answer your phone we need your permission to leave medical information pertaining to your care. We will not leave a detailed message regarding medical information if your name or phone number is not on your recorded message to identify your residence. Without specific permission we will not release any of your medical information to another person. In some cases you may wish for another person to have access to your medical information. Please indicate the full name and relationship of persons you authorize us to discuss your care with. (i.e. spouse, parent, sibling etc.)

By acknowledging signature I am authorizing Otorhinolaryngology Associates to make available necessary medical information to all physicians involved in my care, family members/friends listed above. I assume responsibility to inform the practice of changes in my phone numbers(s) or my preference.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Otorhinolaryngology Associates, P.C. I authorize Otorhinolaryngology Associates, P.C. to release any medical information requested by my health insurance carrier or any other third-party payer needed for any claim consideration; as well as to obtain any information concerning coverage and payments under my insurance policy. If I am without health insurance, payment for the office visit is required at time of service. Additional services will be billed to me. After 120 days, if a personal balance remains without a payment agreement, your account will be referred to our collections agency.

I am responsible for all deductibles, co-insurances, and non-covered services. I understand that if this office does not participate with my insurance plan, I am responsible for payment of any balance not covered by the non-participating insurance carrier.

NOTICE OF PRIVACY PRACTICES

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at Otorhinolaryngology Associates, P.C. who may need to access to your information must abide by the Notice of Privacy Practices. All subsidiaries, business associates (e.g. billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes, or health care operations described in the Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.
Your health care provider must give you a notice that tells you how they may use and share your health information and how you can exercise your health privacy rights. The provider cannot use or disclose information in a way that is not consistent with their notice. The law requires your doctor to state in writing that you received the Notice of Privacy Practices.

CONSENT TO RETRIEVE MEDICAL INFORMATION

As a patient in our practice, I give consent to Otorhinolaryngology Associates, P.C. to retrieve and use my medication history from SureScripts, an electronic prescriptions network. This is an electronic way for our office to access patient prescription benefit information and patient medication history, and route prescriptions to a patient's pharmacy of choice. We can only retrieve medication history from offices that support SureScripts.