DISCLOSURE FORM

The West Tennessee ENT Clinic, P.A. may disclose personal health information about you to your family, close personal friends, or another person that you identify *as long as the information disclosed to those individuals is relevant to their involvement in your care, or the payment for your care.* This Practice also may notify a family member, or another person who is responsible for your care, of your location and general health condition. This form provides you with the opportunity to choose not to have your health information disclosed to individuals involved in your care.

Please initial one of the following to indicate your choice regarding such disclosures:

_____ **I do not object** to my personal health information being disclosed to a family member, friend, or another individual involved in my care.

_____ **Only** disclose my personal health information to the following person(s):

_____

_____

_____

_____ **I object** to my personal health information being disclosed to a family member, friend, or another individual involved in my care.

_____

Patient name (please print)

_____ _____

Signature of patient or patient representative Date

_____

Relationship of patient representative to patient