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Disclosure to Family Members and Friends

In accordance with HIPPA regulations and the Privacy Protection Act, disclosures may be made to family and friends of patients related to their health care treatment and for billing purposes. P & A Associates ENT, P.C. will only disclose information relevant to current treatment.

I, _____ (please print patient name) have agreed that P & A Associates, ENT, P.C. may disclose information regarding my current treatment to the following persons:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

Unless otherwise stated, the patient grants P & A Associates ENT, P.C. permission to speak with the above named persons regarding the patient's treatment, in person and/or by telephone.

_____
Patient's Signature (If 18 or older)

_____ _____
Parent, Guardian, or Responsible Party Signature Relationship to patient

_____/_____/_____
Date

Please Note: The patient may update this information at any time.