Northern Jersey Ear, Nose and Throat Associates, P.A.

AUTHORIZATION FORM FOR ROUTINE SERVICES

Our office respects your privacy. The following is an authorization for miscellaneous services and protocols this office uses. We will make every effort to abide by your instructions. Please take a minute to provide us with following information. Thank you.

Patient: ______________________________ **Date:** ________________

Description of service-check your choice where indicated:

Addressing the patient

Address me by ( ) Mr. ( ) Mrs. ( ) Ms. and last name
( ) my first name only
( ) Nick name: ____________________

Calling you into the office by name

You will be called into the office by the name you have indicated above. If you have any objection to this practice, we will call you in by an assigned number. Please tell our receptionist upon your arrival.

Appointment reminders

( ) I give the office permission to send an appointment reminder card to my home.

( ) I give the office permission to call me and remind me of an appointment.

( ) Please call my home phone: __________________________

( ) Please call my cell phone: __________________________

( ) Please call my work phone: __________________________

( ) Please contact me by E-mail: __________________________

( ) If we get an answering machine or service - may we leave a message?

( ) If we get a family member- may we leave a message?

Please indicate whom we may leave a message with:

_____________________________ Relationship: _______________

_____________________________ Relationship: _______________

Test Results (laboratory, x-ray, etc.)

POLICY: Our office will call you when we receive your test results. We will make every attempt to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours.

Please indicate the best time and number to reach you:

Phone #: _________________________ Time: _____________________

Phone #: _________________________ Time: _____________________

If we are having difficulty reaching you personally...

( ) I give permission for office to leave a message on my answering machine to call office.

( ) I give permission to leave routine test result(s) on my answering machine.

If we are having difficulty reaching you, is there anyone we can leave a message with?

Name: _______________________________ Relationship: __________________

Name: _______________________________ Relationship: __________________

Policy for discussing your medical information with family members:

Our office will never discuss your medical information with a family member unless you have authorized us to do so. If a family member has accompanied you to the office and you do not want them present during the examination or when discussing your medical problem with the physician, please let us know, and we will make every effort to protect your privacy. If you want to authorize release of your personal health information to another party – you will be required to fill out an "authorization" form. Please ask a staff member for this form.

Please give us any additional instructions you may have concerning these policies:

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