# Proliance South Seattle Otolaryngology

**1-HIPAA FORM**

Our Notice of Privacy Practices provides the information about how we may use and disclose the medical information that we maintain for you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

Patient, parent or guardian signature: _____ Date:_____ Time: ____

Printed Name: _____

**2-EMERGENCY CONTACT**

In case of emergency, I authorize SSO to disclose information, and/or review my care with:

| Name: | Phone Number: | Relationship: |
|---|---|---|
| | | |

**3-AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS**

**** (Please check all that apply and note phone #)**

- May leave detailed message on **cell phone** #: _____
- May leave detailed message on **voicemail at home #**: _____
- May leave detailed message at **different location #**: _____
- May leave detailed message on **voicemail at work #**: _____
- May leave information with **spouse** (name): _____
- May leave information with **other family member** (name): _____
- May send detailed email message **by email** to: _____

** With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____

Patient or legally authorized individual signature Date

**4-AUTHORIZATION FOR THE TREATMENT OF A MINOR**

I AUTHORIZE PROLIANCE SURGEONS INC. (South Seattle Otolaryngology) TO TREAT THE MINOR PATIENT NAMED ABOVE.

SIGNATURE: _____ DATE: _____