Ayala

ENT & Facial Plastic Surgery

Patient Preferences Regarding Communication of PHI & HIPAA
(Patient Health Information)

Preferred Method of Communication

: □ Home Phone □ Work Phone □ Cell Phone □ Email □ Guardian

My Preferred method of communication regarding my **medical conditions** is indicated below **(Check One):**
□ Home Phone □ Work Phone □ Cell Phone □ Email □ Mail Letter □ Guardian

If the above method of communication is by phone, please check the appropriate box below (Check one):

□ Leave a message with detailed information: □ Home Phone □ Work Phone □ Cell Phone

□ Leave a message with a call back number only: □ Home Phone □ Work Phone □ Cell Phone

We may leave a message on: □ your answering machine □ Voice Mail □Other: ____________________

Please note that you are responsible for any charges incurred in receiving our communications. For example; if you provide a cell phone number as a method of contact, then you are responsible for any charges by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special instructions or requests regarding our communication with you. For example; Please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to our Practice and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **Patient** or **Legal Guardian**.
If you want to add additional contacts (other than the patient or Legal Guardian) That Ayala Nasal & Sinus Institute is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Ayala Nasal & Sinus Institute to list as your Emergency Contact in the event an emergency situation was to take place at our office.

____________________	____________________	____________________
Contact Name	Relationship to Patient	Contact Phone Number
□ **Billing Account Information**	□ **Medical Condition Information**	□ **Emergency Contact**

____________________	____________________	____________________
Contact Name	Relationship to Patient	Contact Phone Number
□ **Billing Account Information**	□ **Medical Condition Information**	□ **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

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Patient Name (Please Print

____________________________________ ____________________
Signature of Patient, Parent, or Legal Guardian **Date**

Address: 800 E. Dove Ave Suite F & G ● McAllen, Texas 78504 Ph: 956-631-4515 Fax: 956-627-6015