Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

Cathy M. Thackrey, Au.D., CCC-A
Audiology
Hearing Aids

AUTHORIZATION FOR COMMUNICATION OF HEALTH INFORMATION

I have been informed and agree to the procedures by which this office may communicate my protected health information. I hereby consent to communication via:

□ Email: _____

□ Voice message on the following telecommunication lines:

_____ _____

OPTIONAL AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

My protected health information may be discussed with or released to the following family members and/or personal acquaintances:

1.) Name _____ Relationship _____

2.) Name _____ Relationship _____

3.) Name _____ Relationship _____

Please note that without this authorization, this office cannot discuss medical issues with spouses, children, etc. who may inquire on behalf of the patient, an exception being custodial parents of children under the age of 18 and/or personal representatives of incapacitated patients. You may be required to fill out an additional form to release records to other entities, including physician offices, etc.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices and this signed document.

ACKNOWLEDGEMENT AND AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way related to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will all lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

_____ _____
Patient's Name (Print) Date

_____ _____
Patient/Personal Representative (Signature) Relationship to Patient
*if completing online, you may leave blank and sign upon appointment arrival

This notice is good for 3 years from the date of completion. Authorization may be revoked at any time by providing written notice to our office or completing a new acknowledgement form.