Lake Jackson
Ear, Nose and Throat

Patient Consent Form

Please review the statements below and initial where indicated.

Last Name | First Name | Middle initial | Date of Birth

Consent to Evaluate and Treat

I authorize Lake Jackson ENT to evaluate and provide treatment for my otolaryngology needs, as well as those of my auditory system. This may include medical management of a variety of ear, nose and throat disorders; comprehensive audiometry threshold evaluation and speech recognition; tympanometry; acoustic reflex testing, and earmold impressions.

Initials _____

HIPAA Consent (copies of the law available upon request)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out treatment and/or billing, or where applicable by law.

Initials _____

Consent for Medical Photography

I agree to have photographs taken in the course of 1) pre-operative evaluation and planning; 2) intra-operative or procedural documentation or evaluation; or 3) post-operative documentation or evaluation. The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Initials _____

Authorization to Include in Educational and/or Marketing Outreach

Authorizing marketing communication from this practice means I may:

A. Receive communication concerning treatment alternatives or other health-related products or services.

Marketing Authorization Options:

- ☐ I wish to receive Marketing Communications from this Practice Only
- ☐ I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates
- ☐ I **DO NOT** wish to receive **ANY** Marketing Communications **Initials** _____

Your information will never be released or sold to any outside entity. Any other release of your Protected Health Information requires a signed HIPAA release form. You may opt out of future educational/marketing outreach by writing to us at:
215 Oak Drive South, Suite F, Lake Jackson, TX 77566

Patient Signature _____ Date _____