April 14, 2003 LONG ISLAND ENT ASSOCIATES

516 931-5552

Dear Patient:

As per HIPPA rules and regulations you are required to inform this office how you wish us to communicate with you in regards to your Personal Health Information (PHI). At times we may need to contact you to confirm your appointment, schedule surgery, return your phone calls or to give you results of labs, xrays, scans, or consultations. We are required to follow your written instructions specifically, except where we feel following the instruction would be detrimental to your health or in case of emergency. Please be very specific as to how we are to reach you, where we can leave messages and with whom. **Please fill in or circle.**

You may/may not call me at Home-# ____________________

You may/may not leave a message on my answering machine

You may leave a message with (please circle) no one, my spouse, my children, other ____________________

You may/may not call me at Work-# ____________________

You may/may not leave a message on my voice mail

You may/may not call me on my Cell Phone# ____________________

You may/may not leave a message on my cell phone

You may/may not Fax me at # ____________________

You may change your decision at any time by filing a request for change with our office manager at 875 OLD COUNTRY ROAD, PLAINVIEW NEW YORK 11803 FAX 516 931-6563

______________________________ __________

Signature of Patient(or Personal Representative) Date

______________________________ / ____________________

Printed name of personal Representative /Relationship to Patient

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