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**HIPAA Disclosure, Release of Information, Consent, Communication, Photo ID**

Please read and initial each policy statement and sign the bottom of the form.

**PATIENT PRIVACY POLICY:** I acknowledge that a copy of Concord Otolaryngology and Alliance Audiology’s patient privacy policy was offered or given to me.

Initials: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION:** I authorize the release of information to my doctor or audiologist, any physician involved in my care, as well as to my insurance company to process my medical claims.

Initials: \_\_\_\_\_

**CONSENT:** I authorize Concord Otolaryngology or Alliance Audiology, LLC and any qualified, authorized person employed by them to perform and/or initiate medical or diagnostic evaluation and treatment and authorize or order related services and agreed upon products on my behalf.

Initials: \_\_\_\_\_

**COMMUNICATION AGREEMENT:** I understand that as part of my healthcare, Concord Otolaryngology/Alliance Audiology will need to contact me in order to remind me of an appointment, provide test results, give instructions or provide other information. I have indicated my preferred method of contact on the registration form.

Initials: \_\_\_\_\_

**PHOTO ID:** Due to new government regulations regarding insurance fraud and mistaken identity as well as Meaningful Use requirements with our new Electronic Medical Record system, we will be taking webcam photos of our patients (parent & child for a patient who is an infant/toddler). In addition, patients and/or guardians may be asked for a driver’s license or other photo ID.

Initials: \_\_\_\_\_

My signature below acknowledges that I have read and agree to the above listed policies.

\_\_\_\_\_  
 Signature of Patient/Legal Guardian

\_\_\_\_\_  
 Date