LEWIT WORRELL, MD
FOOTHILL ENTCARE SPECIALISTS

Confidentiality Agreement

The HIPPA privacy rules gives patients the right to request restrictions on usage and disclosures of their protected health information.

I, the undersigned give permission to Foothill ENT Care Specialists its employees and associates to share any and all aspects of my medical records with the following people:

Name	Relationship

In the event that you need to be contacted please check one of the following:

☐ I wish to be contacted
- At home
- By phone, ok to leave message. Telephone:_____

☐ I wish to be contacted
- At Work: Telephone:_____

☐ I wish to be contacted
- By cellphone
- Ok to leave message: Telephone:_____

☐ Other_____

Patients Name (Print):_____

Signature: _____ Date:_____