

# COMMUNICATION OF HEALTH INFORMATION

## ENTACC

### *Ear, Nose & Throat Associates of Chester County*

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\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

Do you permit ENTACC to leave messages on your answering system? YES NO

Please list the preferred phone number: \_\_\_\_\_

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Please list any family members or others who may be involved in coordinating your care or payment for care. Please indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT:	TYPE OF INFORMATION			
		ALL	SCHED/ APPT.	MEDICAL	BILLING/ INS.
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Specific Instructions or Limitations:** \_\_\_\_\_

We will rely on the information provided on this form when communicating with family members or others involved in your care unless you request a change. Please notify our office promptly if you wish to alter the designations above.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if applicable)

To revoke this authorization, please send a written request to the address listed above.

*Please contact our office with any questions:*  
610-363-2532