PERMISSION TO GIVE MEDICAL INFORMATION

This information is needed for **ANYONE** calling our office for information regarding the patient. Please list any and all persons (including yourself) that you wish to be authorized to have this information. If the patient is a **minor** both parents (grandparents, step parents, etc. - **regardless of guardianship/custody**) that you wish to be authorized persons should be listed or we will be unable to speak with them regarding the patient. Please also check the information you are willing to release to said authorized persons below.

I, _____, hereby authorize the physician and staff of Ear, Nose, Throat and Allergy Center to give information concerning the health and well being of _____ (patient) to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The following information may be given to the above individuals:

_____ Appointment time and date

_____ Test/Lab results

_____ Medications

_____ Procedures

_____ Any other information regarding my health

_____ Leave message on answering machine

I understand I may revoke this consent at any time by given written notice to the persons or organization making the disclosure.

Signed: _____ Date: _____
(Patient/Parent/Legal Guardian)