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HIPAA Release Form

Who may we release your information to?

Patient Name: **Date of Birth:**

☐ **I do not authorize ENT Medical Services, PC, to share my medical or financial information with anyone. Please sign and date below.**

☐ **I authorize ENT Medical Services, PC, to share my information with the following individual(s):**

Person #1

Name (Please print):

_____

Relationship to patient: _____ Phone #: _____

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

Person #2

Name (Please print):

_____

Relationship to patient: _____ Phone #: _____

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

Person #3

Name (Please print):

_____

Relationship to patient: _____ Phone #: _____

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

STATEMENT OF CONSENT

I am aware that I may withdraw my consent at any time except to the extent that action has been taken in reliance on this statement of consent.

X_____ _____

Signature of Patient or Patient's Guardian/Representative Date

_____

If signed by Patient's Guardian/Representative, please print name and relationship to patient