ONSLOW
EAR NOSE & THROAT

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please note if your wish for anyone other than yourself to communicate with the doctor or our staff in regard to your care, appointments or account status. I understand that sensitive information, like STDs (including HIV/AIDS) results, pregnancy test results, mental health or substance abuse will not be shared unless specifically stated by me at the time.

Patient Name _____ Date of Birth _____

Do not release information about _____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Patient Signature: _____ Date Signed: _____

Phone Release

I authorize Onlsow Primary Care staff to leave messages with anyone that answers my phone or on my answering machine in regards to appointments, test results, or issues in regard to my care.

Patient Signature: _____ Date Signed: _____