Associated Coastal ENT
Ear, Nose, Throat & Facial Plastic Surgery

PATIENT PRIVACY AUTHORIZATION

PATIENT: _____ Date of Birth: _____

Please be advised that I hereby authorize the release of my personal information or medical records for the sole purpose of my treatment to the following:

Primary Care Physician _____

Other: **Other doctors you are referred to, surgery centers, billing companies, hospitals, diagnostic facilities, laboratories, pharmacies.**

EMERGENCY CONTACT: _____ Phone_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO ADDITIONAL PERSON

I hereby authorize Richard B. Allen, M.D., Michele L. Richards, M.D. Christopher L. Slack, M.D., Charles J. Zeller IV, D.O. and Nicole M. Thompson, ARNP to release any information on my condition to the following persons:

(PLEASE INDICATE BY INITIALS)

INCLUDE: _____ HIV/AIDS _____ ALCOHOL/DRUG ADDICTION _____ MENTAL HEALTH

_____ I DO NOT AUTHORIZE ANY PERSONS OTHER THAN MYSELF TO RECEIVE INFORMATION.
_____ I AUTHORIZE ALL PERSONS OTHER THAN MYSELF TO RECEIVE INFORMATION.
_____ OR SPECIFIC PERSONS ONLY:
_____ It is OK to leave messages on my home answering machine and/or mobile phone voicemail.
The best number to reach me is _____.

_____	_____	_____
Name	**Relationship**	**Contact Number**
_____	_____	_____
Name	**Relationship**	**Contact Number**

AUTHORIZATION FOR PERSONS OTHER THAN PARENT/GUARDIAN TO BRING MINOR CHILD TO APPOINTMENTS (excludes surgery) AND RELEASE OF OTHER HEALTH INFORMATION OF MINOR

_____	_____	_____
Name	**Relationship**	**Contact Number**
_____	_____	_____
Name	**Relationship**	**Contact Number**

I hereby authorize this office to speak to the above mentioned persons in regards to my medical care and other information pertaining to my treatment. I hereby understand without my consent, this office cannot speak to any family members or caregivers. This authorization can be canceled by me at any time in writing. This authorization will expire 2 years from the date below.

_____ _____
Patient/Guardian Signature **Date**