GLACIER
EAR NOSE THROAT

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# Permission to Disclose Medical/Billing Information

_____ _____
**(Print-Patient's Name)** **(Date of Birth)**

I give permission to Glacier Ear, Nose & Throat &/or Glacier Hearing services to discuss my medical/billing information with the individual(s) indicated below. Please include any individual (i.e. spouse) who you might want us to communicate with at any time regarding your bill or medical information. If they are not listed, we cannot speak to them. I understand that this permission will remain in effect until I submit a written request stating my intentions otherwise.

| **Name** | **Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

****If patient is a minor, please list any adult(s) who may accompany the minor to appointment(s)****

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please specify methods of contact that we may ***NOT*** use (check all that apply):

Home Telephone: _____ Work Telephone: _____

Mobile Telephone: _____

_____ _____
**(Patient Signature)** **(Date Signed)**

****Please Note****
**If patient listed above is unable to sign on their own behalf (i.e. minor, incapacitated) and you are acting as this patient's guardian or representative, please complete the section below:**

_____ _____
**(Print-Guardian/Representative's Name)** **(Relationship to Patient)**

_____ _____
**(Signature-If not Patient)** **(Date Signed)**