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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)****

_____	_____
_____	_____
_____	_____

What is the best method of contact for you? Home Cell Work

Are there any methods of contact that we may **NOT** use?

Please specify: _____

(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)