Associates of Otolaryngology

Authorization for Release of Information to Family Members

Patient Name_____Date of Birth_____

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Associates of Otolaryngology to release my medical and/or billing information to the following individual(s):

1._____Relation to patient_____

2. _____Relation to Patient_____

3. _____Relation to Patient_____

I do not wish to allow anyone to receive any information [ ]

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclose.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature_____ Date_____