RELEASE OF INFORMATION-for family, friends

I, _____ DOB _____,
give permission to NAENT to release my medical records and share any and all medical information, including but not limited to; test results, billing information, referrals, appointments and medication requests, with the following people:

Name _____ Phone _____ Relationship _____

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Name _____ Phone _____ Relationship _____

NOTICE: By signing this form, I understand that in accordance with HIPPA privacy regulations, we can only release information to persons or leave messages on the alternative sources (i.e. voicemail/answering machine) indicated on this form. We CANNOT accept verbal authorization. Thank you.

I understand I have the right to revoke this release in writing at any time.

Patient/Guardian Signature: _____

Patient/Guardian Printed Name: _____

Date signed: _____

NORTHERN ARIZONA EAR NOSE & THROAT
DAN DOWNS M.D.
BEN FELDMAN M.D.
BOARD CERTIFIED OTOLARYNGOLOGY

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