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Lubbock
SINUS DOCTOR

Ear, Nose & Throat
Laser Surgery
Hearing Testing &
Hearing Aids

OTOLARYNGOLOGY-HEAD AND NECK SURGERY

MEDICAL INFORMATION RELEASE FORM

(HIPAA Release Form) – PLEASE READ ALL INSTRUCTIONS

Name: _____ Date of Birth: _____/____/_____

(IF PT IS MINOR): Mother's name_____

Father's name_____

Release of Information

[Please mark appropriate boxes below and list names on lines provided]

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____ [ ] Child(ren)_____

[ ] Other_____

[ ] Information is *not* to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

In my absence, I authorize the following person(s) to make medical decisions for (minor's name)_____. 1)_____
2)_____ 3)_____

Only the following may bring (minor's name) _____for medical treatment.
1)_____ 2)_____
3)_____ 4)_____

NOTE: ID WILL BE REQUIRED FOR THOSE LISTED ABOVE

Messages

Please call [ ] my home_____ [ ] my work_____

[ ] my cell _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Signed:_____Date:____/____/_____

Witness:_____Date:___/____/_____

IN ORDER TO INSURE PATIENT PRIVACY NO AUDIO OR VIDEO RECORDING IS PERMITTED

IF YOU ARE ACCOMPANIED BY ANYONE TODAY THEY MUST BE LISTED ON THIS FORM