Allergy Asthma Ear Nose & Throat

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I, ______________________, have been offered or received the Privacy Notice for Allergy Asthma Ear Nose & Throat and signed the authorization for the following:

Please list below whom we can speak with and release information to:
(Please Understand a Medical Records release will need to be signed)

Family or Friend Name:	Relationship to the Patient:	Phone Number:	Leave Messages and Speak with:	Review Your Account with:	Ok to Pick up Prescriptions, Orders, and Medical Records:

I allow messages to be left on the telephone number I provided on the patient information form.

____Yes   ____No

Signature_______________________________   Date______________________

Relationship to the Patient:_______________________

Refusal of Above:________________________________