ENT Associates
SOUTHWEST

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DISCLOSURES TO FAMILY AND/OR FRIENDS DOCUMENTATION FORM

Patient Name: ____ DOB: ____________________

Family Members/Friends Involved in My Care:

___ I agree that this office may disclose my private health information to only the following individuals listed below:

____
Name Relationship

____
Name Relationship

____
Name Relationship

___ I do not want my private health information disclosed to any individual asking about me, regardless of whether or not they may state they are a family member or friend.

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___ I hereby authorize that this office may disclose any and all of my private health information available in my patient record.

____ I hereby authorize that this office may disclose ***only*** the private health information specified below:

____

____

****

Signature:____
Patient/Responsible Party Date

Relationship, if other than patient: ____

(Patient may change their decision at any time by notifying staff and filling out the following line.)

____
Revised Date Patient's Initials