WESTERN MICHIGAN ENT

HIPAA Disclosure Form

Patient Name: ____

Date of Birth: _______________

Release of Information

[ ] I author ze the release of my protected health information including the diagnosis, records, examination rendered to me and claims information. This information may be releasec to:

[ ] Family ____

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[ ] Other/Physicians____

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

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

Messages

Please call: [ ] my home [ ] my work [ ] my cell Number: ________________________

If unable to reach me:

[ ] you may leave a detailed message

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

Patient/Parent/Guardian Signature: ____

Date: _______________

06/15/18 sm