Chart #

NORTHEAST EAR, NOSE & THROAT CENTER

Patient Name: _____ **DOB**: _____

Permission to Communicate / Authorization to Treat

So that we may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss the patient's appointments, referrals, test and lab results, and any other health/financial information.

*If you **do not** want to share any personal or medical information with anyone other than your insurance company to file claims, please initial here: _____ and sign/date below.

I give permission for NorthEast Ear, Nose & Throat Center to share health (H) and/or financial (F) information with the below-named caregivers.

This authorization also acts as permission to treat if patient is under 18 years of age and one of the following caregivers is accompanying my child.

I, _____, give the below-named caregivers permission to accompany my child, _____, who is under 18 years of age, during treatment in my absence.

Info Relationship	Name to Share	Phone Number	Check
_____	_____	_____	☐ H ☐ F
_____	_____	_____	☐ H ☐ F
_____	_____	_____	☐ H ☐ F
_____	_____	_____	☐ H ☐ F

I understand I have the right to revoke this at any time. A revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____ _____

Signed (Patient or Parent/Legal Guardian) **Relationship** **Date**