

CONSENT FOR RELEASE OF INFORMATION

As a patient in our practice, from time to time we may need to communicate with you or with physicians involved in your care, when you are not in the office. To preserve your privacy, we would like you to indicate your preferred method for us to communicate information to you and ask your permission to communicate with your physicians.

1. In the event that no one is available to answer your phone we need your permission to leave medical information pertaining to your care by the following methods.

Please circle the methods that you will authorize our practice to use:

Home Phone	yes	no	Home Voice mail	yes	no
Work Phone	yes	no	Work Voice Mail	yes	no
Cell Phone	yes	no	Cell Voice Mail	yes	no
Pager	yes	no	Fax	yes	no
Answering Machine	yes	no	Via mail	yes	no

We will not leave a message if your name or phone number is not on your recorded message to identify your residence.

2. Without specific permission we will not release any of your medical information to another person. In some cases you may wish for another person to have access to your medical information. **Please list the full name and relationship of persons you authorize us to discuss your care with.**
(i.e. spouse, parent, sibling etc.)

By signing below I am authorizing Bethlehem Ear Nose & Throat Associates to make available necessary medical information to all physicians involved in my care, family members/friends listed above and by the methods I have circled

I assume responsibility to inform the practice of changes in my phone numbers(s) or my preference.

Signature: _____ Date: _____