ENT and Audiology Center of Southlake

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CONSENT TO DISCLOSE PROTECTED HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____

I, _____, give my consent for the physicians and staff at Southlake ENT to disclose my private healthcare information to the following people. This consent will be valid until revoked by the patient.

Name: _____

Relationship to Patient: _____

Telephone: _____

Name: _____

Relationship to Patient: _____

Telephone: _____

Name: _____

Relationship to Patient: _____

Telephone: _____

_____ _____
Patient signature Date

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