MORELAND
EAR, NOSE & THROAT

Communication of Health Information Authorization and Appointment Reminder

I _____, _____ authorize
Patient First Name *Last Name* *Middle Initial* *Date of Birth*

Moreland Ear, Nose & Throat to contact me via the following methods:

Please check the appropriate boxes. Checking a box gives us permission to leave health information (e.g., test results, prescription refills, appointment and billing information).

Ways to Communicate Health Information	Leave a Voicemail Message	Leave a Message With Whoever Answers
Home Phone: (_____) _____-_____	☐ Approved	☐ Approved
Work Phone: (_____) _____-_____	☐ Approved	☐ Approved
Cell Phone: (_____) _____-_____	☐ Approved	☐ Approved
Email: _____	☐ Approved	
Letter	☐ Approved	

For INCOMING Phone Calls ONLY
You may release information to the following:

Name	Relationship
_____	_____
_____	_____
_____	_____

Unless otherwise requested, we may remind you of an upcoming appointment by letter, telephone call, voice message or a message with the person who answers your telephone. Appointment reminders will include the date and time of your appointment, the provider you are scheduled to see and the medical center location. I understand that signing this document will authorize the release of my information in the manner stated above. I understand that a written notification is necessary to cancel this request.

_____
Signature of Patient or Personal Representative *Relationship if Not Patient* *Date*

Note: Personal representative means the parent, guardian or legal custodian of a minor or adult patient. If you have a Durable Power of Attorney, we will need documentation on file before releasing information.

I am giving permission for Moreland Ear, Nose & Throat to administer medical treatment to my minor child _____ without my presence.
Name

This consent will remain in effect until further notice is given in writing.

_____
Printed Name *Relationship*

_____
Signature *Date*