OTOLOGIC CENTER
EAR CARE EXCELLENCE

Medical Information Release Consent

The Otologic Center has adopted a policy that requires our staff to obtain written authorization from the patient to share your medical information with ANYONE other than you (the patient). This policy is to protect your rights to privacy. However, we also acknowledge that you (the patient) may want to share your medical information with a family member and/or close friend.

Please fill out the form below if you would like to authorize individuals to have access to your private health information. Any changes to add or eliminate ANY individual from this consent MUST be submitted to our office in writing IMMEDIATELY. Please note it is OPTIONAL to release information to other individuals, but form must be signed regardless.

Please list names of individuals you wish to GRANT ACCESS TO YOUR MEDICAL INFORMATION.
(Release MUST be signed and dated.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give my consent to my doctor and/or staff of Otologic Center, Inc. to share my private health information with the individuals I (the patient) have chosen above.

Please sign and date form below regardless of choosing to release information to other individuals or not.

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____

Date: _____

RECEIPT OF PRIVACY POLICY

I, _____, have received a copy of the Notice of Privacy Practices for Otologic Center, Inc.

_____ _____

Signature of Patient or Parent/Guardian Date

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