Willamette ENT
Ear • Nose • Throat

Clark R. Thompson, MD
Bruce C. Johnson, MD, FAAOA
Gary J. Nishioka, MD, DMD, FARS, FAAOA
Joseph H. Allan, MD, FACS
John S. Donovan, MD
Jared C. Hiebert, MD

Consent to Share Health Information

I, _____ DOB _____

Hereby authorize Willamette Ear, Nose, Throat & Facial Plastic Surgery, LLP, to release verbal Medical Information regarding myself to the following person listed below. I understand this may include information regarding diagnostic treatment, lab and x-ray results. This will not include information regarding HIV/AIDS, genetic testing, mental health or drug and alcohol information.

This information may also be shared by letter or fax if the provider determines it to be a more appropriate form of communication.

Person(s) Authorized to receive information:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

This authorization will remain in effect until:

Option 1 Expires on _____ /_____ /_____ / _____
Initials

Option 2 No expiration unless canceled _____
Initials

_____ _____
Patient Signature Date Signed

_____ _____
Parent/Guardian Signature Date Signed

I am canceling the authorization to share my medical information as of _____ /_____ /_____ / _____
Initials