Willamette ENT® Ear • Nose • Throat

503-581-1567 · ENTsalem.com

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 information may include information regarding diagnostic treatment, lab and x-ray results. This information 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 cancelled [ ]
Initials

_____ _____
Patient Signature Date Signed

_____ _____
Parent/Guardian Signature Date Signed

I am cancelling the authorization to share my medical information as of ____/____/____ [ ]
Initials

Fax to: 503-399-1229 · Mail to: WENT · 3099 River Rd S. Ste 150 · Salem, OR 97302 or bring to your appointment.