

PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

SPOUSE OR CAREGIVER CONSENT

I authorize the following individuals to have access to my private health care information. I further understand that if this list of spouse/or caregiver authorization should change I am responsible to inform Ear, Nose, & Throat Center of Pueblo, PLLC and complete a new consent.

1. _____
2. _____
3. _____

Patient Signature/or Legal Representative _____

Date _____

MESSAGE AUTHORIZATION

I hereby authorize Ear, Nose, & Throat Center of Pueblo, PLLC to leave messages regarding my test results and appointment information on my home telephone.

Patient Signature/or Legal Representative _____

Date _____

Witnessed By _____ Date _____