Lakeside Ear Nose Throat and Allergy, LLC

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Release of Medical Information

To Others Involved in Your Healthcare

As stated in our Notice of Privacy Practices, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. We request that you designate the individuals with whom we may discuss your protected health information.

I, _____, give **Lakeside Ear, Nose, Throat and Allergy** and or the colleagues permission to discuss my protected health information with the following persons:

Name	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

I understand that I may rescind or modify this information at any time. Such changes must be in writing to **Lakeside Ear, Nose, Throat and Allergy.**

For more information:

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