Ear, Nose & Throat *Specialty Care*

Consent To Communicate

I authorize Ear, Nose & Throat *Specialty Care* to communicate with the following person(s) regarding my medical care and information:

Name	Relationship	Phone Number	Scheduling	Medical	Billing
			Y N	Y N	Y N
			Y N	Y N	Y N
			Y N	Y N	Y N

This authorization will expire 36 months from the date signed, unless an earlier date is provided here: ________________________.

Patient printed name: _____________________________________

Patient signature & date: __________________________________

Staff name: ____________________ Witness name: ___________________