

Cape Cod Ear, Nose and Throat Specialists

Patient's Account # _____

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES

1) By signing below, I hereby authorize Cape Cod E.N.T. Specialists to disclose my Protected Health Information to the following family member(s) and/or friend(s):

Signature _____ Date _____

Family Member/Friend Name	Relationship to Patient	Telephone No.

I give permission for messages to be left on my answering machine.

Signature Date _____

I do not wish to be called. Signature: _____ Date _____