IOWA ENT CENTER PLLC

REQUEST FOR CONFIDENTIAL/ALTERNATE COMMUNICATIONS

Patient information (please print):

_____
Last Name First Name Middle Name

Birth date: _____ /_____ /_____

I, the undersigned, hereby authorize Iowa ENT Center to discuss medical information concerning the above-named patient to:

Name	**Relationship**	**Phone**

Medical information includes, but is not limited to, demographic information, identification of providers of care, diagnosis, and procedures. This may relate to medical information, treatment, and billing information.

Please check all that apply:

☐ **You may contact me or leave a message/result for myself or my minor children at:**

Phone: _____

Phone: _____

Email: _____

☐ **You may leave a message with a family member (please specify):**

Name: _____ Relationship: _____

Phone: _____

☐ **I decline to have any medical information released and/or shared.**

I understand that I may revoke this information at any time by sending a written notice to the office.

Please note: This authorization does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.

Signature: _____ **Date:** _____ /_____ /_____

Relationship (if not the patient): _____

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