Ear, Nose and Throat Associates of Northern Colorado

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any preotected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated party/parties must be verified before the release of any information.

Patient name:_____

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Print name (If the patient is a minor, parent/guardian's name and relationship)

_____

Signature Date