OTOLARYNGOLOGY
ENDOSCOPIC SINUS SURGERY
HEAD AND NECK SURGERY
AUDIOLOGY & HEARING AIDS

EAR SURGERY
FACIAL SKIN CANCER
MAXILLOFACIAL SURGERY
FACIAL PLASTIC SURGERY

Asheville
EAR NOSE & THROAT

Authorized Designee

PATIENT INFORMATION

_____
First Middle Last

DOB: _____/_____/_____

I hereby authorize the designated parties below to request and receive the release of any protected health information regarding treatment, payment, or administrative operations related to treatment and payment regarding the patient stated above. I understand that the identity of designated parties must be verified before the release of any information.

AUTHORIZED DESIGNEES

Name: _____ Relationship to Patient: _____

Phone: _____ Alt Phone: _____

Name: _____ Relationship to Patient: _____

Phone: _____ Alt Phone: _____

Name: _____ Relationship to Patient: _____

Phone: _____ Alt Phone: _____

Name: _____ Relationship to Patient: _____

Phone: _____ Alt Phone: _____

Signature: _____ Date: _____
Patient or parent/legal guardian