MODERN NOSE CLINIC
ALLERGY, SINUS & SNORING

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Consent to Share Health Information

I, _____ DOB: _____

Hereby authorize Modern Nose Clinic to release verbal Medical Information regarding myself to the following person listed below. I understand this information may include information regarding diagnostic treatment, lab and x-ray results. This information will not include information regarding HIV/AIDS, genetic testing, mental health or drug and alcohol information.

This information may also be shared by letter or fax if the provider determines it to be a more appropriate form of communication.

Person(s) Authorized to receive information:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

This authorization will remain in effect until:

Option 1 Expires on _____/_____/_____ [ ]
Initials

Option 2 No expiration unless cancelled [ ]
Initials

_____ _____
Patient Signature Date Signed

_____ _____
Parent/Guardian Signature Date Signed

I am cancelling the authorization to share my medical information as of ____/____/____ [ ]
Initials