ENT CENTERS OF EXCELLENCE

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

_____

Patient Name (Please Print)

To whom communications for the patient named above may be directed. PLEASE WRITE ANYONE BELOW WHOM YOU WISH TO ALLOW DISCUSSION WITH US IN REGARED TO MEDICAL ISSUES OE TO BILLING INORMATION. If you do not include all parties, the caller will not be given any information regarding your medications, your treatment, your condition, or your billing. (you need not include other physicians.)

_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #

_____ _____

Patient Signature Date