MORELAND EAR, NOSE & THROAT GROUP
PROFESSIONAL HEARING SERVICES
262-547-1614

Communication of Health Information Authorization and Appointment Reminder

I ____, ____________________ authorize

Patient first name, last name, middle initial Date of birth

Moreland Ear, Nose & Throat and Professional Hearing Services to contact me via the following methods:

Please check the appropriate boxes – checking a box gives us permission to leave health information (i.e. test results, prescription refills, appointment and billing information).

Ways to Communicate Health Information	Leave message on answering machine:	Leave message with whoever answers telephone:
Home phone ( ) _______ - __________	☐	☐
Work Phone ( ) _______ - __________ Ext. __________	☐	☐
Cell phone ( ) _______ - __________	☐	☐
Email ____________________ ☐ Approved	Letter ☐ Approved	

For INCOMING phone calls ONLY– You may release information to the following:			
Name	Relationship	Name	Relationship
____________________	__________	____________________	__________
____________________	__________	____________________	__________
____________________	__________	____________________	__________

Unless otherwise requested, we may remind you of an upcoming appointment by letter, a telephone call, a message on your answering machine or voicemail, or a message with the person who answered your telephone. Appointment reminders will include the date and time of your appointment, the provider you are scheduled to see, and the medical center location. I understand that this will authorize the release of my information to the manner stated above. **I understand a written notification is necessary to cancel this request.**

______________________________ ____________________ __________
Signature of patient or personal representative Relationship if not patient Date

Note: Personal representative means the parent, guardian or legal custodian of minor patient or adult patient. If you have Durable Power of Attorney, we will need documentation on file before release of information.

I am giving permission for Moreland Ear, Nose, & Throat and Professional Hearing Services to administer medical treatment to my minor child ____________________ without my presence.

This consent will remain in effect until further notice is given in writing.

____________________ ____________________ ______________ __________
Name Printed Signature Relationship Date

Form 545 R5/19