MIDWEST
EAR, NOSE & THROAT
"Feel better."

HIPAA Approved Contacts

Please list the individuals you give permission to have access to and discuss your protected health information:

Name	Date of Birth	Phone Number	Relationship

This form will remain in effect until a written request is received to change or an updated form is filled out by you.

_____ _____

Patient Name Account Number

_____ _____

Signature Date