Main Line
EAR, NOSE & THROAT of Paoli
Your center for advanced ENT care

Authorization to Release Protected Health Information

Full Name______________________________ Birth Date____________________

It is the office policy of Main Line Ear, Nose & Throat of Paoli and their staff not to release any confidential and/or unauthorized information by home telephone, work telephone, or cellular telephone voice mail. We will not leave messages on a voice mail that does not have the name or telephone number on the recorded message. Information will not be left with any unauthorized person who may answer the telephone.

I authorize the staff at Main Line Ear, Nose & Throat of Paoli to contact me by any of the following methods and assume the responsibility to notify us whenever this information changes:

Cellular phone/or voice mail	yes ☐	no ☐
Home telephone/or voice mail	yes ☐	no ☐
Work telephone/or voice mail	yes ☐	no ☐
E Mail	yes ☐	no ☐

I authorize Main Line Ear, Nose & Throat of Paoli and/or their staff to communicate medical information pertaining to:

Lab/ Imaging results ☐ Medical test results ☐ Appointment information☐

If you would like to have information released to anyone other than yourself please complete the following. List names of people that you authorize and what type of information we may release to them.

Name____________________ Relationship___________ Type ____________________

Name____________________ Relationship___________ Type ____________________

Name____________________ Relationship___________ Type ____________________

Patient/Legal Representative Signature: ______________________________
Name: ______________________________ Date__________________________