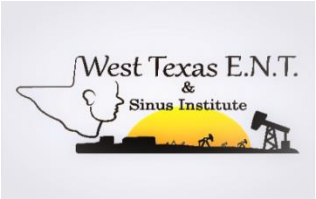

Permission for disclosure to family, friends and/or caregivers

To be completed by patient/designee:

I understand my health information is protected and confidential. I give permission for West Texas ENT and sinus Institute physicians and staff to discuss my health related matters with family, friends, caregivers, and other designated persons listed below.

Patient name: _____

DOB: _____

Patient Signature: _____ Date: _____

Relevant health information may be shared with the following people:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship