Ear, Nose and Throat Associates of Northern Colorado
& The Hearing and Balance Clinic
Affiliated with Ear, Nose and Throat
Associates of Northern Colorado

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties; must be verified before the release of any information.

Authorized Designees:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

_____ _____
PATIENT NAME DATE

_____
PARENT NAME (IF THE PATIENT IS A MINOR)

_____
PATIENT SIGNATURE (**PARENT** IF PATIENT IS A MINOR)

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