Mitchell Ramsey, M.D.
Kent Keele, D.O.
Kyle Tubbs, MD.
David Healy, M.D.
Tracy Pollath, P.A.-C

GLACIER
EAR NOSE THROAT

Hannah M. Sims, Au.D. CCC-A
Kay Lynn Benko, M.S. CCC-A
Ann S. Hinds, CCC-A, F-AAA

Permission to Disclose Medical/Billing Information

_____ _____

(Print Patient's Name) **(Date of Birth)**

I give permission to Glacier Ear, Nose & Throat &/or Glacier Hearing services to discuss my medical/billing information with the individual(s) indicated below. Please include any individual (i.e. spouse) who you might want us to communicate with at any time regarding your bill or medical information. If they are not listed, we cannot speak to them. I understand that this permission will remain in effect until I submit a written request stating my intentions otherwise.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

(Patient/Guardian Signature) **(Date)**

If the patient is a minor complete below

****Please list any adult(s) who may accompany the minor to appointment(s)****

Name	Relationship
_____	_____
_____	_____

****Please Note****
If patient listed above is unable to sign on their own behalf (i.e. minor, incapacitated) and you are acting as this patient's guardian/representative, please complete the section below:

_____ _____
(Print Guardian/Representative's Name) (Relationship to Patient)

_____ _____
(Signature Guardian/Representative) (Date)