Lawrence Otolaryngology Associates, LLC.
1112 West 6th St, STE 216
Lawrence, KS 66044

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
All information must be filled out to be valid.

I _____ hereby authorize Lawrence Otolaryngology
Print Patient Name and Date of Birth

Associates, LLC to disclose any or all medical information they deem necessary to the following people:

Name: _____ Relationship_____

Address _____ City/State_____

Primary Phone # _____ Secondary Phone # _____

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Name: _____ Relationship_____

Address _____ City/State_____

Primary Phone # _____ Secondary Phone # _____

****

Name: _____ Relationship_____

Address _____ City/State_____

Primary Phone # _____ Secondary Phone # _____

I understand that I may revoke this consent at any time in writing except to the extent that action has been taken in processing it. I understand that this authorization will remain in effect for one year from the date it is signed unless I specify a date here (allow at least two weeks) _____.

Patient/Parent or Guardian/Authorized Person Signature _____

Date _____