



**PRIVACY POLICY: CONSENT FOR COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE**

Note: We will not discuss your care with anyone other than those listed below, with the exception of your primary care and/or referring physician.

Bridger Ear, Nose & Throat may discuss information regarding your care and treatment with the following individuals.

If we may ONLY speak with you, check here:  and sign below.

Name	Relationship to Patient	Type of Information Allowed (Circle)
		ALL MEDICAL BILLING
		ALL MEDICAL BILLING
		ALL MEDICAL BILLING

SPECIFIC INSTRUCTIONS OR LIMITATIONS: \_\_\_\_\_

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

To revoke this authorization, please submit a written request to Bridger Ear, Nose & Throat, PLLC.