

**RELEASE OF MEDICAL INFORMATION BY ALTERNATIVE MEANS**

**Patient Name** \_\_\_\_\_  
**SSN/DOB:** \_\_\_\_\_

**Dependent Children:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

**I authorize McCalla Ear, Nose and Throat, P.C. to release the following medical information as listed below: (Circle Yes or No)**

Return Appointments	yes	no	X-ray Results	yes	no
Out Pt. Testing	yes	no	Return Calls	yes	no
Lab Appointments	yes	no			

**Signature and Date:** \_\_\_\_\_

**McCalla Ear, Nose and Throat, P.C. can release the above information to the following people:**

Name/Relation \_\_\_\_\_

Name/Relation \_\_\_\_\_

Name/Relation \_\_\_\_\_

**Signature and Date:** \_\_\_\_\_

**McCalla Ear, Nose and Throat, P.C. can release the above information by the following means: (enter phone number or address)**

Answering Machine \_\_\_\_\_ Voice Mail \_\_\_\_\_

Mobile Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Fax \_\_\_\_\_

**Signature and Date** \_\_\_\_\_

**I revoke this Release of Medical Information by Alternative means as of \_\_\_\_\_  
Date**

\_\_\_\_\_  
**Signature**