FYZICAL®
Therapy & Balance Centers

Authorization – People Involved In Patients Care

Name: _____ **DOB:** _____

I have the right to choose family members, friends or others to be involved in talks about my health care. The people listed below may receive any verbal information needed to be involved in my care or to help me make decisions about my care. By signing this form, I give my permission for staff within Michigan ENT & Allergy Specialists to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options and other information from previous services I have had, either in hospitals or other locations.

- I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.
- I know that listing a person on this form does not allow them to get or copy my medical records.
- People listed on this form are not allowed to give consent for services for me.
- For a minor, parents are assumed to be designated except for those services, which the minor has given consent under Michigan law.

LIST PEOPLE THAT MAY RECEIVE VERBAL INFORMATION ABOUT YOUR CARE

NAME OF PERSON	RELATIONSHIP	CONTACT PHONE NUMBER(S)	ALLOWED TO RECEIVE VERBAL INFORMATION ABOUT YOUR CARE	Emergency Contact
			☐	☐
			☐	☐
			☐	☐

☐ _____ I do NOT wish to name anyone. (if box is checked, initial)

I can update this form at any time by telling a Michigan ENT & Allergy Specialists staff member AND by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to a Michigan ENT & Allergy Specialists staff member.

PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

Patient Signature: _____ Date: _____

☐ Patient is under 18 years of age or otherwise unable to consent because _____

_____

Parent / Legal Guardian /
Patient Advocate / Next of Kin Signature: _____ Date: _____