ALLIANCE
INVOLVEMENT OF CARE

PATIENT NAME (PRINT): _____**DOB:** _____**DATE:** _____

PHYSICIAN: _____

I hereby request that the following person(s) be identified as participants in my care or payment process. I understand that Alliance ENT & Hearing Center may use and disclose health care information without authorization to the person(s) identified below when those individuals are involved in my healthcare. Alliance ENT & Hearing Center will make a reasonable effort to provide only the necessary information to the person(s) for this use and disclosure.

NAME	RELATIONSHIP	PHONE NUMBER	TYPE OF INFORMATION TO BE RELEASED

1. I understand that this authorization will:(must check one)
   - ❑ Expire one year from the date signed by the patient or the patient's representative; or
   - ❑ Be effective for the lifetime of the patient unless revoked (see #2 below)

Initials: _____

2. I understand that I may revoke this authorization at any time by notifying Alliance ENT & Hearing Center in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Alliance ENT & Hearing Center prior to their receipt of the revocation.
Initials: _____

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.
Initials: _____

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE **DATE**

_____

RELATIONSHIP OF AUTHORIZED REPRESENTATIVE

201 N. MAYFAIR RD, SUITE 515, MILWAUKEE, WI 53226
17000 W. NORTH AVE, SUITE 105E, BROOKFIELD, WI 53005
9969 S. 27TH STREET, 2ND FLOOR, FRANKLIN, WI 53132

WWW.ALLIANCEENT.COM
OFFICE: (414) 727-0910
FAX: (414) 727-0920