Patient Name Date
DOB Account #

Permission to Communicate and Permission to Treat Form

So that Charlotte Eye, Ear, Nose and Throat Associates, PA may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss the patient's appointments, referrals, test and lab results and any other health/financial information. This form will also act as permission to treat in the event the patient is less than 18 years of age and one of the following caregivers is accompanying the child for treatment.

You are not required to complete this form.

I, _____, give permission for Charlotte Eye, Ear, Nose and Throat, Associates PA to share health/financial information with the below named caregivers.

I, _____ give the below named caregivers permission to accompany my child _____who is under 18 years of age, during treatment in my absence.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____
Signature Relationship to Patient Date

_____
Printed Name

_____ _____
Witness Date