CHARLOTTE EYE
EAR NOSE & THROAT
ASSOCIATES, P.A.

Patient Name: _____ Date: _____

DOB: _____ Account #: _____

Permission to Communicate and Permission to Treat Form

So that Charlotte Eye Ear Nose & Throat Associates, P.A. 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 under 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 & Throat Associates, P.A. 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