Michigan Ear Institute, P.L.L.C.

Any information related to my medical care is considered confidential and will not be released to anyone without my permission. I hereby give permission for any medical information related to my treatment to be given to:

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

THIS OFFICE MAY: (CHECK ALL THAT APPLY)

_____Leave test results on your cell phone (number) _____

_____Leave a message at work to call the office (work number)_____

_____Leave a message on my home answering machine to call the office_____

_____Leave test results on answering maching

_____Call me at work with results (number) _____

_____Send medical information to any healthcare provider that I am referred to (lab, physicians, etc.)

_____NONE OF THE ABOVE

PRINT PATIENT NAME_____

PATIENT OR LEGAL
GUARDIAN SIGNATURE_____DATE_____

30055 Northwestern Hwy.
Suite 101
Farmington Hills, MI 48334

3555 W. Thirteen Mile Rd.
Suite N-210
Royal Oak, MI 48073

18181 Oakwood Blvd.
Suite 402
Dearborn, MI 48126

26850 Providence Parkway
Suite 130
Novi, MI 48374

Phone (248) 865-4444 Fax (248) 865-6161 TDD (248) 865-4191