FAIRFAX ENT & FACIAL PLASTIC SURGERY

Patient Name	Patient Date of Birth

1. AUTHORIZED PERSON(S): (please print full name/relationship)
I hereby authorize the persons listed below to be involved in my care:

_____ _____
Full Name Relationship to Patient

_____ _____
Full Name Relationship to Patient

2. CHECK AUTHORIZATION TYPE:

☐ I hereby authorize Fairfax ENT & Facial Plastic Surgery to leave a detailed message regarding my medical care on my voicemail, or with anyone answering the telephone.
Fairfax ENT & Facial Plastic Surgery will use the phone numbers currently on file for you.

☐ To consent to Medical or Surgical treatment from _____ to _____.

☐ To receive verbal and/or access to my medical information.

☐ Other: _____
_____.

3. *COMPLETE DISCLOSURE TYPE:*

Disclosure Type:
Verbal and/or hard copy disclosure is authorized for **any and all information** about medical history, mental and physical condition, including HIV infection, AIDs, or ARC, drug and alcohol use, and any other personal information **unless otherwise specified:**
_____.

4. SIGNATURE AND DATE:

I, the requester/representative, have filled out this form completely. All blank fields are intentional. I understand that this authorization is voluntary. This authorization is in effect for a *maximum of 12 months from the date of signature. In the event of the patients death, this* authorization will be null and void.

_____ _____ _____
Print Name Signature Date

If signed by anyone other than the patient, or parent of a minor child, please print name below and indicate the relationship. Please submit documents to show authority.

_____ _____
Print Authorized Representative's Name Relationship to Patient