

Prefix / Last Name:	First Name:	Sex:
Preferred Name:	Date of Birth:	
Address:	City:	Prov: Postal Code:
Primary Phone No.:	Secondary Phone No.:	
Email:	Occupation:	
Personal Health No.:		
Emergency Contact Name:	Relationship:	Phone:
Legal gaurdian's name(s) if patient is a child:		

Referral Source:

FAMILY DOCTOR

Full Name:

Phone:

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

☐ **RELEASE:** I hereby authorize Sonaris Ear Center to release my healthcare information to the agency and/or individuals listed below. I have read and understood the privacy policy concerning the storage and use of my personal information:

RELEASING AGENCY/INDIVIDUAL NAME(S):

☐ **OBTAIN:** I hereby authorize Sonaris Ear Center to obtain my health care information from the agency and/or individuals listed below

RELEASING AGENCY/INDIVIDUAL NAME(S):

☐ **OPT OUT:** I do not wish to have my health care information released to any entity. I understand that releasing my health care information to the referring entity is for my benefit and may impact future care, however, I have chosen to decline this option. The referring entity may be notified of my decision to not release my health care information.

PATIENT/LEGAL GUARDIAN SIGNATURE:

DATE: