



Snake River Ear, Nose, and Throat

Dr. Rod Kack or Dr. Marilyn Righetti
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Authorization for release of patient health information.

Date: _____

I hereby authorize the use or disclosure of the below named individual's health information as described below.

Information shall be released to: _____

Information shall be released from: _____

Purpose or need for information: _____

Patient name: _____
(Print)

Date of birth: _____

Signature: _____
(Patient, parent, or guardian)