Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Simran Kaur, NP-C
Nurse Practioner

Please complete the following:

You have my consent to leave messages with family members or significant others and/or on my answering machine. YES _____ NO _____

You have my consent to discuss my medical treatment/condition with the following:

Name	Relationship
Name	Relationship
Name	Relationship

Assignment & Release

I also authorize the release of any information required to process insurance claims, including any information relating to alcohol, drug abuse, and/or AIDS. I authorize release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians and others involved in the medical and/or financial aspects of my medical care. This authorization may be revoked in writing by me at any time.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of Estrella Ear, Nose and Throat may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure or referral and that I have the option to decline such treatment or seek further information.

_____ _____
Patient Signature or Signature of Parent/Guardian Date

_____ _____
Patient Name (if patient is a minor) Relationship to Patient