



THE
EAR, NOSE & THROAT
CENTER, AMC

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that The Ear, Nose & Throat Center, AMC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized permission, except as required by law.

PLEASE PRINT CLEARLY

Patient Name: _____
Last First MI Maiden

Date of Birth: _____ Social Security Number: _____

Patient Address: _____
Street City State Zip Code

Daytime Phone: _____ Evening Phone: _____

I authorize _____
Name of the Physician and/or Facility Mailing Address

To release to _____
Name of the Physician, Facility, Other or Self Mailing Address

Fax Number: _____

The following information: (Please check and date)

- () Entire Record: _____ () Progress Notes: _____
- () Lab: _____ () Correspondence: _____
- () X-ray: _____ () Records from other facilities: _____
- () Other: _____

Purpose of Disclosure: () Medical Care () Legal () Insurance () Personal
() School () Work () Other: _____

READ THE FOLLOWING CAREFULLY BEFORE SIGNING

By signing this form, I understand that I am authorizing the release or disclosure of the requested health information as marked above in accordance with any specifications I have made. I also understand that the health information to be released may include reference to treatment or history of: **1) Mental or behavioral health, 2) Alcohol or drug abuse, 3) HIV and/or AIDS.**
**INITIAL THE SPACE PROVIDED IF YOU DO NOT AUTHORIZE THE RELEASE OR DISCLOSURE OF 1, 2, OR 3 _____

I understand that this authorization will expire one (1) year from the date it is signed by the patient or legal representative, that it may only be used for the disclosure listed above and that it will become part of my medical record.

I understand that I may revoke this consent at any time with written request to be effective on the date notified except to the extent that action was already taken in reliance on this signed authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and would no longer be protected by the federal privacy regulations.

I understand that I may see and obtain a copy of the records described in this authorization upon my request. Additionally, I may receive a copy of this authorization upon my request.

I understand that The Ear, Nose & Throat Center, AMC may receive compensation for the use or disclosure listed on this authorization.

Patient's or Legal Representative's Signature

Date Signed

Printed Name of Patient's Representative

Relationship to Patient

REVOCACTION – SIGN THIS SECTION ONLY IF YOU WANT TO REVOKE THIS AUTHORIZATION

I hereby revoke this authorization.

Patient's or Legal Representative's Signature

Date Signed

OFFICE USE ONLY: Date form received: _____

Disclosure date: _____ Disclosed by: _____