

REQUEST/AUTHORIZATION TO RELEASE, COPY OR INSPECT PROTECTED HEALTH INFORMATION

PATIENT NAME:
PATIENT ADDRESS:

DATE OF BIRTH:
MR#:

I have read and understand that this authorization will expire 365 days after I sign it or my requested expiration Date:
I understand that I may revoke this authorization at any time by notifying the provider organization in writing, but if I do it will not have any effect on any actions they took before they received the revocation.

X _____
Date

X _____

X _____

Signature of Patient or Patient's Representative

Printed Name of Patient or Patient's Representative

Relationship to Patient: _____

**Identification is required at time of pickup

For Record Release or Copies:

By signing below, I hereby authorize Ear, Nose & Throat Associates, dba The Surgery Center, or The Hearing Center the authorization to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand my refusal to authorize disclosure of my personal health information will have no effect on my enrollment, eligibility for benefits or the amount my insurance company pays for services I receive. I have the right to revoke this authorization in writing, submitted to the Privacy Officer.

I AUTHORIZE RECORDS RELEASED TO BE RELEASED TO:

X Name/Company Name: _____

X Address: _____

X City/State/Zip: _____

Telephone Number: _____ Fax Number: _____ Release via: Fax US MAIL Pick -UP

X Information to be Released/Copied: ENT/THC AND The Hearing Center Records Other:

- All Clinical Records
- Progress and Treatment Notes
- Audio Tests
- Balance Tests
- Other _____

X Record Date Range: From: _____ to _____ Expiration: _____

X Reason for Disclosure: (I would like this information released for the following purpose):

- Personal Use (charges may apply – based on Indiana State Law, our practice may charge for copying charges, including postage related to production of my information.
- Hand-carry to another medical provider
- Attorney
- Disability
- Other: _____