EAR, NOSE & THROAT ASSOCIATES, P.C.
ENT REALTY CORP., DBA THE SURGERY CENTER
THE HEARING CENTER

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

PATIENT NAME: DATE OF BIRTH:
PATIENT ADDRESS: 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: _____