EAR NOSE & THROAT SPECIALTIES P.C.

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AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient name **Date of birth**

Address

City **State** **Zip code**

As required by the Privacy Regulations, ENT Specialties may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

_____

Patient Health Information authorized to be disclosed to above party (must be specific):

_____

For the specific purpose of (describe in detail):

_____

Effective dates for this authorization: _____ through _____. This authorization will expire at the end of the above period. If I do not specify an expiration date, this authorization will expire in 6 months.

Signature of patient or patient's authorized representative **Date**

Authorized signature of facility **Date**

I understand that I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.