Authorization to Use or Disclose My Health Information

Patient Name:_____ Date of Birth:_____

My Authorization
You may use or disclose the following health care information (check all that apply):
□ Office visit note(s) □ Lab Report(s) □ Biopsy Report(s) □ Imaging Report(s)
□ Operative Report(s) □ Test Result(s) □ Audiogram(s)
□ Other:_____

I am requesting this information be released from:

Name:_____

Address:_____

Phone: _____ Fax: _____

You may disclose this health information to:

Name:_____

Address:_____

Phone: _____ Fax: _____

The purpose of this authorization: _____
This authorization expires: □ on _____, _____, 20_____
Month Day Year

OR

□ when the following event occurs_____
(example: on my death, after resolution of a specific issue)

My Rights
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Comprehensive ENT based upon this authorization. I may not be able to revoke this authorization if it's purpose was to obtain insurance. The way to revoke this authorization is by writing a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient's Printed Name Date

_____ _____
Signature of patient or legal representative Relationship to patient