



**AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION**

**THIS RELEASE MUST BE FAXED TO THE APPROPRIATE LOCATION PROVIDED AT THE BOTTOM OF THIS PAGE**

Patient Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize ADVANCED ENT and ALLERGY to **send/obtain** my protected health information as follows:

- Information disclosed from: \_\_\_\_\_
- Information disclosed to: \_\_\_\_\_

Method of Disclosure:  Copies Picked Up  Copies Faxed to: \_\_\_\_\_  
 Copies Mailed  Other: \_\_\_\_\_

**Mark those that apply. Cross out any item you do not authorize to be released.**

- Entire record, including mental health, HIV, and/or substance abuse records.
- Records regarding treatment for the following condition or injury: \_\_\_\_\_
- Records covering the period of time \_\_\_\_\_ to \_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to our Site Administrator at ADVANCED ENT and ALLERGY. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that ADVANCED ENT and ALLERGY may not condition treatment or payment on whether I sign this authorization.

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

This authorization expires one year from signature date. I certify that I have received a copy of this authorization. This authorization expires ninety (90) days from the date of this signature.

\_\_\_\_\_  
Signature of patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

**Indiana Locations**

New Albany - State Street  
812-945-3557 • Fax 812-949-3599  
Jeffersonville  
812-206-1910 • Fax 812-206-1941

**Kentucky Locations**

Dixie Highway Caritas Medical Mall  
502-995-5525 • Fax 502-995-5527  
Dupont Medical Center  
502-893-0159 • Fax 502-213-3853  
The Quarry Center - Poplar Level  
502-459-3760 • 502-459-3717

**Kentucky Locations**

LaGrange  
502-222-4589 • Fax 502-213-3853  
Shelbyville  
800-561-2122 • Fax 502-213-3853  
Bardstown  
800-561-2122 • Fax 502-213-3853