AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

THIS RELEASE MUST BE FAXED TO (502) 371-4017

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