Patient Authorization for Use and Disclosure of Health Care Information

Patient Name: _____ SSN: _____ DOB: _____

I authorize Ear, Nose and Throat, Ltd. to release health care information of the patient named above to:

Name of Individual or Entity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to be released:

_____ Complete Medical Record _____ Specific Medical Information Only; Please release the following:

_____

_____

(Please describe above the information to be used or disclosed, including descriptors such as date of service, type of service provided and level of details to be released, etc.)

This protected health information is being used or disclosed for the following purposes:

_____

_____

(Please list specific purposes. Write "at the request of the individual" when disclosure is requested by the patient.)

This authorization expires on: _____
Date

Or when the following event occurs: _____

I understand that I have the right to revoke this authorization, in writing, at any time and that a revocation will not cover the information already released. To revoke this authorization, written notification must be sent to: **Privacy Officer, Ear, Nose and Throat, Ltd., Norfolk, VA 23502 / Fax 757-627-6471.**

I understand that once this information is released by Ear, Nose and Throat, Ltd., the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law. I understand that the treatment requested from Ear, Nose and Throat, Ltd. is conditioned on my signing this authorization because this treatment is for the sole purpose of providing specific information to the party named above.

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

COST OF COPYING RECORDS

Processing Fee	**$15.00**
Paper Copies	$0.50 per page
Electronic Copies	
Disk	$5.00
Thumb Drive	$15.00