Comprehensive ENT
HEAD & NECK SURGERY PC

Authorization to Disclose My Health Information

Patient Name:_____ Date of Birth:_____

I. My Authorization

You may disclose the following health care information (check all that apply):

□Biopsy Report(s)	□Medical History	□INCLUDE: (Indicate by Initialing)
□Lab Report(s)	□Treatments	___Alcohol/Drug Treatment
□Consultation Report(s)	□Medications	___Mental Health Information
□Notes from other physicians	□Surgical Procedures	___HIV-Related Information

□ My health information relating to the following treatment or condition:_____

□My health information for the date(s):_____

□Other:_____

I am requesting this information be released from:

Name (or title):_____ Relationship:_____

Organization:_____ Phone:_____ Fax:_____

Address:_____

Address/P.O. Box City State Zip

The purpose of this authorization:_____

This authorization ends: □ on (date)_____

□ when the following event occurs_____

(If no date is specified, this authorization will expire one year from the date signed below)

II. 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 its 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 or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship to the patient

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