ENT™

EAR, NOSE & THROAT ASSOCIATES, P.C.

REQUEST/AUTHORIZATION TO RELEASE, COPY OR INSPECT PROTECTED HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____ ID# _____

I hereby authorize ☐ Ear, Nose & Throat Associates ☐ The Surgery Center ☐ The Hearing Center

Other (include address and phone) To Release my Information to: *(Include even if releasing records to yourself.)*

Name/Facility _____

Address _____

City _____ State _____ ZIP _____

Telephone Number _____ Secure Fax Number _____

Release via: ☐ Fax ☐ U.S. mail ☐ Pick up (Identification is required at time of pickup.)

Information to be Released/Copied: *(please check all that apply)*

☐ All Clinical Records ☐ Progress and Treatment Notes ☐ Audio Tests ☐ All Diagnostic Testing

☐ Pathology ☐ Labs ☐ Billing ☐ Other

Record Date Range—From (month/year): _____ to _____

Reason for Disclosure: *(I would like this information released for the following purpose):*

☐ Attorney ☐ Disability ☐ Hand-carry to another provider ☐ Personal use**

***Charges may apply. Based on Indiana State law, our practice may charge for copying, including postage, related to production of records.*

For Record Release or Copies:

By signing below, I hereby authorize Ear, Nose & Throat Associates, dba The Surgery Center, or The Hearing Center to disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand my refusal to authorize disclosure of my personal health information will have no effect on my enrollment, eligibility for benefits or the amount my insurance company pays for services I receive. I have the right to revoke this authorization in writing, submitted to the Privacy Officer.

I have read and understand that this authorization will expire 365 days after I sign it or on my requested expiration date. I understand that I may revoke this authorization at any time by notifying the provider organization in writing, but if I do, it will not affect any actions they took before they received the revocation.

_____ _____

Date Printed name of Patient or Patient's Representative

_____ _____

Signature of Patient or Patient's Representative Relationship to Patient

OFFICE USE ONLY:

RECORDS PREPARED BY (NAME/DEPT) _____ DATE _____

☐ Faxed ☐ Mailed ☐ Picked up on _____ at _____ ☐ Other _____

Date Location

(260) 426-8117 • entfortwayne.com • contact@entfw.com

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