plains
ear nose throat
& facial plastic surgery

Authorization for Release of Patient-Identifiable Health Information

PATIENT NAME: _____ Date of Birth:_____
Last First (legal) Middle Initial

HEALTH RECORD #:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   _____

   Address:_____
3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   ☐ Doctor's chart notes from (date) _____ to _____

   ☐ Operative reports

   ☐ Laboratory results from (date) _____ to _____

   ☐ Audiology from (date) _____ to _____

   ☐ X-ray/CT scan from (date) _____ to _____

   ☐ Other _____

   ☐ Entire record
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

   _____

   Address: _____

   For the purpose of: _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on following date, event, or condition:_____.

   If I fail to specify an expiration date, event, or condition, this authorization will expire in (six months, one year, as applicable to state law or facility guidelines.)
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Plains Ear, Nose, Throat & Facial Plastic Surgery *privacy officer*.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to patient Signature of Witness