ENT & Allergy Specialists

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ My entire medical record

☐ My medical records dated from _____ to _____

☐ Protected health information relating to, _____ (Specify diagnosis, procedure, condition, injury, etc.)

☐ Other (please explain): _____

1. I authorize ENTAS to disclose my health information to: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

2. Disclosure of my health information is being made for the purpose(s) of: _____

☐ At the request of the individual or individual's personal representative

☐ Permission to return to work, sick note or medical excuse

☐ Insurance enrollment or coverage

☐ Life insurance, automobile insurance or disability insurance claim

☐ Employment purpose (please specify): _____

☐ Other (please specify): _____

3. Authorization for disclosure of my health information will expire in 60 days or on: _____

☐ Please specify date: _____

☐ Please specify event, if not a specific date: _____

☐ Adjudication of claim

4. I understand that if the person or entity to whom ENTAS is disclosing my information is not a doctor, health care provider or health plan, the information may not be protected by HIPAA and that that person may use or disclose that information to other noncovered entities. I understand that the information in my health record may include information relating to sexually transmitted diseases, 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 drug abuse.

5. I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment from ENTAS but that it may affect my ability to return to work or receive an employee or insurance benefit.

6. I understand I have the right to inspect or copy information disclosed by this Authorization. I understand I may revoke (cancel) this Authorization at any time. The revocation must be in writing. ENTAS cannot be held responsible for having disclosed information in reliance on this Authorization before receiving a written revocation.

7. I understand that ENTAS and its workforce are released from legal responsibility or liability for disclosing protected health information authorized by my signature below.

8. I acknowledge I had an opportunity to ask questions before I signed and that I may receive a copy of the signed Authorization.

_____ _____

Print Name of Individual or Individual's Personal Representative | Date

_____ _____

Signature | Individual's Date of Birth