Ear, Nose, Throat & Plastic Surgery Associates, P.C.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize Ear Nose Throat and Plastic Surgery Associates, PC to disclose the following protected health information as described below. I agree to disclosure of information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal regulation, Part 2 , if any: social services records, in any; and psychological services records, if any; including communications made by me to any employee of this office; or any records pertaining to HIV infection, acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex or a test for any such disease, including records protected under ACT 488, Public Acts of Michigan, 1988, if any; or any other records or test related to any other sexually transmitted disease, if any; which may be contained within the records specified below.

Specific information to be disclosed:

□ My Medical Record (visits, reports, labs, imaging, etc.) □ My Billing Record □ My appointment information
□ All health information related to _____ □ Other: _____
□ Other: _____

The above protected health information may be disclosed to and used by the following individual or entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

Relationship: _____

This protected health information is being disclosed for the following purpose:

_____

This authorization shall be in force and effect until: ____/____/____ . If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing, by presenting 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 with the right to contest a claim under my policy.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. 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 ensure 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 re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, they may be directed to the privacy officer or contact.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Relation of Representative **Witness**