

Authorization for Disclosure of Protected Health Information

Name of Patient

Birth Date

Mailing Address

City, State, Zip

Phone Number

This form authorizes ENT Associates of NH, PA, 85 Spring St, Laconia, NH 03246 (603-524-7402) (FAX 603-524-0945) to disclose [] my medical record and protected health information as described below to: SEND TO

_____ located at _____
Name Complete Mailing Address

for the purpose as described below:

INFORMATION TO BE DISCLOSED:

- [] Entire Record
- [] Progress Notes from _____ to _____.
- [] Audiologic Exam
- [] Other _____

For:
_____ the dates _____ to _____.
_____ the entire duration of treatment.

Note: this authorization shall not include treatment provided after the date of this authorization, or records from any other physician or facility.

_____ I also authorize release of privileged information including, but not limited to alcohol/drug abuse, AIDS
init. here HIV status and testing, venereal disease, genetic testing, mental health issues, psychotherapist/social worker communications. Note any exceptions:

Purpose for Need of Disclosure: (check appropriate categories)

- ___ Further Medical Care
- ___ Insurance Benefits
- ___ Legal Action
- ___ Changing Physician
- ___ Personal
- ___ Other: _____

Redisclosure - I understand that the health information used or disclosed as a result of this authorization may no longer be protected by federal or NH law protecting its confidentiality and could be subject to redisclosure by the recipient without obtaining my authorization or consent. I hereby release ENT Associates of NH, PA from any and all legal responsibility or liability that may arise from this authorization.

Expiration Date: This authorization is good until the following date: _____ or for 90 days from the date signed. Any subsequent information must be accompanied by another authorization.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Please allow 7 - 10 days for release of records.

Authorized by: _____