EAR, NOSE & THROAT ASSOCIATES, P.C.
ENT REALTY CORP., DBA THE SURGERY CENTER
THE HEARING CENTER

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 ☐ US 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.m

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 have any effect on any actions they took before they received the revocation.

X _____ **X** _____
Date **Printed name of Patient or Patient's Representative**

X _____ **X** _____
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*