PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I _____, authorize the release my confidential health information through the release of a copy of my designated medical record or a summary or narrative of my designated medical record containing protected health information (PHI), to the person(s) or entity listed below:

Patient Name:	**Patient Date of Birth:**
Patient Social Security No.:	**Patient Driver's License No. (include state)**
Patient Address:	
Patient Address cont.:	

I request ENT Carolina to release the following information: (Check All That Apply)

	Complete Medical Record*		Allergy Testing and Treatment		Office Visit Notes/Procedures
	Operative Reports		X rays, CT Scans, MRI's		Pictures (Please specify CD or Print)
	Laboratory Reports		Pathology Reports		Medication List(s)
	Other:				

**I understand this authorization may include information regarding HIV or AIDS, drug or alcohol abuse, or statutory protected diseases such as venereal diseases that may be contained in the records maintained by ENT Carolina.*

I direct this information to be released [ ]from: [ ] to: (Check one)

Name:	Phone:	**[ ] from [ ] to (check one)**
Address:	Fax:	ENT Carolina 2520 Aberdeen Blvd. Gastonia, NC 28054 Phone: 704-868-8400 Fax: 704-868-8493

I authorize the release of the requested records to the identified person(s) or entity via:[ ] Pick-up [ ] U.S. Mail [ ] Fax

I understand that my designated medical record and PHI will be used or disclosed for the purpose of medical care. I further understand that ENT Carolina will not receive payment or other renumeration from a third party in exchange for using or disclosing my PHI.

This authorization will expire in sixty (60) days from the date of my signature below. I understand that I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Medical Records Department at ENT Carolina, 2520 Aberdeen Blvd. Gastonia, NC 28054.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability act of 1996. ENT Carolina, its employees, officers, and physicians are hereby released from any legal responsibility for the use or disclosure of the above information to the extent indicated and authorized herein.

I do not have to sign this form for me to receive treatment from ENT Carolina. In fact, I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Printed Name of Patient or Authorized Representative | Relationship to Patient

_____ **I understand that the requested records will be provided within 30 days from receipt of this request and that a fee for preparing and furnishing this information may be charged in accordance with Federal and State law.**

Initial