

**AUTHORIZATION FOR THE USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Date of Request: _____ Patient Name: _____ Date of Birth: _____

Patient Ph#: _____ Patient Soc Sec #: _____ Patient Address: _____

I *(print name)* _____ hereby authorize **Austin Ear, Nose & Throat Clinic** to use or disclose my protected health information, for a purpose other than treatment, payment or health care operations, as specified below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below. ***(Patient/Guardian Signature required on other side of this page).***

I. Description of Protected Health Information to be used or disclosed *(check all that apply)*:

- The patient's entire medical record. **OR** Medical Data/Information as related to:
- specific condition(s): _____
 - specific dates of service: _____
 - specific medications: _____
 - other: _____
- Billing records for dates of service: _____

II. List the name or other specific identification of the person(s) or class of person(s) who are authorized to make the requested use or disclosure of my Protected Health Information *(for example; personal attorney, school district, employer)*:

III. This authorization permits Austin Ear, Nose & Throat Clinic to **send the protected health information **ONLY to the following name and address or fax number:****

IV. List the purpose of the requested use or disclosure: _____

V. This Authorization shall expire on _____. After this date, Austin Ear, Nose & Throat Clinic can no longer use or disclose the specified protected health information without first obtaining a new authorization form.

VI. I understand that I have the right to revoke this Authorization in writing *(separate form)* and acknowledge that Austin ENT Clinic will use or disclose my Protected Health Information in reliance upon this Authorization. Austin ENT Clinic will accept written revocations of this authorization via: Certified Mail, Fax *(call office for fax#)*, or in person.

Procedure for Revocation of an Authorization

Upon request, AENTC will provide a Revocation of Authorization Form to any individual seeking to revoke a previously signed Authorization Form. Upon receipt of a signed and dated Revocation of Authorization Form, we will terminate all uses and disclosure of the individual's Protected Health Information covered by the specific Authorization that is revoked. The revocation will be effective on the date that the signed form is received or the date specified on the form, whichever is later and shall not apply to information used or disclosed prior to the individual's revocation. The revocation form must be signed and dated by the patient or the patient's authorized Personal Representative. The signature must be identified as that of the Patient or the Patient's authorized Personal Representative

VII. By signing this Authorization, I acknowledge that I have read and understand this Authorization and I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

Signature (Patient) Date _____ or _____ Signature of Authorized Representative Date _____

Description of Authorized Representative's authority to sign for the patient *(please print)*

Signature (Witness) _____ (Date) _____