Adult & Pediatric
Ear, Nose & Throat
Hearing Aid Services

I hereby authorize the use or disclosure my Protected Health Information (PHI) as described below:

____ ____________________ _______________
Patient Name (please print) Date of Birth SSN (last four digits)

PHI to be used or disclosed:

- ☐ Entire Record
- ☐ Medical Record Only
- ☐ Financial Record Only
- ☐ Other (please specify) ____
- ☐ Office Visit Notes
- ☐ Laboratory/Pathology/Radiology Results
- ☐ Operative Notes

Purpose of Disclosure:

- ☐ Patient Request
- ☐ Other (please specify) ____

I authorize my PHI to be released/disclosed from:

____ _________________________
Name Phone

____ _________________________
Address Fax

____
City State Zip **O Authorization in Effect through _____________**

I authorize my PHI to be released/disclosed to:

ADULT & PEDIATRIC EAR, NOSE & THROAT
501 South Drake Road Kalamazoo, Michigan 49009
Phone: (269) 343-1296 Fax: (855) 233-7157

- I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the practice.
- I further authorize that a photocopy of this release may be used in place of the original. I understand that there may be a charge that I am responsible for prior to the completion of the request.

____ ________________________ _______________________
Signature (patient or legal representative) Date Relationship to Patient

____
Print Name (patient or legal representative)

Patient Instructions for Release of Protected Health Information (PHI)

Limited Patient Authorization for Disclosure of PHI

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your PHI. The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person/entity you have named on the form. Use of this form will enable us to provide your health information to a person/entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have to our staff.

- **Patient name, social security number, and date of birth** - This information is needed for identity verification and will be maintained in a confidential manner.
- **PHI to be used or disclosed** - The type and extent of information you wish to be disclosed
- **Purpose of disclosure** - Regulations require that we identify the purpose for disclosing your PHI. You have the right to keep the purpose to yourself by selecting “Patient Request.”
- **PHI to be released from** - This form identifies Adult & Pediatric Ear, Nose & Throat as the disclosing entity.
- **PHI to be released to** - Enter the person/entity to whom you wish your PHI to be released. This information may be provided in verbal, written, or electronic formats.
- **Expiration or termination** - This authorization will expire upon the date indicated or when revoked in writing.
- **Right to revoke or terminate** - You may revoke this authorization at any time prior to the designated date. This request must be in writing and specify the person/entity to whom it applies. You may not revoke your authorization for a date preceding the date of the revocation request.
- **Signature and date** - This form is not effective or binding until it is signed and dated by the patient or his/her legal representative.
- **Redisclosure statement** - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization.
- **Non-conditioning statement** - Our practice does not place conditions for treatment on the use of the authorization.
- **Copies** - We will provide you with a copy of the signed authorization upon request.