Massachusetts E.N.T. Associates
Medical History Form

Date of visit:_____
Name:_____ **D.O.B.:**_____
Address:_____
Phone: Home_____ **Work**_____ **ext.**_____ **Cell**_____
Email address:_____
Name and city of Primary Care Physician:_____
Name and city of Physician requesting consult: _____
Primary Reason for this office visit:

Major Medical Illness: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ High blood pressure	☐ Heart disease	☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ TB
☐ Emphysema/COPD	☐ GERD	☐ Stomach ulcer	☐ Stroke	☐ Arthritis	☐ Gout
☐ Fibromyalgia	☐ Kidney disease	☐ Kidney stones	☐ Hepatitis	☐ Liver disease	
☐ Atrial Fibrillation	☐ Sleep apnea	☐ Neuropathy	☐ Mitral valve prolapse	☐ Other heart valve disease	
☐ Thyroid disease	☐ Pancreatitis	☐ Depression	☐ Bipolar Disease	☐ Other Psychiatric Disease	
☐ Glaucoma	☐ Cataracts	☐ HIV	☐ Other immune disorder	☐ Bleeding disorder	

☐ Cancer (Type and treatment:_____)
☐ Other:_____

Previous Operations: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ Tonsillectomy	☐ Adenoidectomy	☐ Ear tubes	☐ Other ear surgery	☐ Septoplasty	☐ Sinus surgery
☐ Rhinoplasty	☐ Gall bladder	☐ Appendix	☐ Lung surgery	☐ AV fistula	☐ Kidney surgery
☐ Brain surgery	☐ Joint surgery	☐ Back surgery	☐ Carotid surgery	☐ Heart surgery	☐ Eye surgery
☐ Thyroid surgery	☐ G-tube	☐ Gastric bypass	☐ Colon surgery	☐ Other stomach/intestinal surgery	

☐ Other:_____

Current Medications (Including Aspirin/Herbal medicines/Over the counter medications):

Allergies to medications, foods and environmental causes:

Pharmacy name and address:

Family History: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ High blood pressure	☐ Heart disease	☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ TB
☐ Emphysema/COPD	☐ GERD	☐ Stomach ulcer	☐ Stroke	☐ Arthritis	☐ Gout
☐ Fibromyalgia	☐ Kidney disease	☐ Kidney stones	☐ Hepatitis	☐ Liver disease	
☐ Atrial Fibrillation	☐ Sleep apnea	☐ Neuropathy	☐ Mitral valve prolapse	☐ Other heart valve disease	
☐ Thyroid disease	☐ Pancreatitis	☐ Depression	☐ Bipolar Disease	☐ Other Psychiatric Disease	
☐ Glaucoma	☐ Cataracts	☐ HIV	☐ Other immune disorder	☐ Bleeding disorder	

☐ Cancer (Type and treatment:_____)
☐ Other:_____

Social History: Have you ever smoked? ☐ Yes ☐ No **How many years?**_____
How much? **When did you quit?**_____
Alcoholic beverages per day: _____
Recreational drugs: Prior use? ☐ Yes ☐ No **Current use?** ☐ Yes ☐ No
Occupation:_____
Hobbies:_____ **Do you use your voice professionally?** ☐ Yes ☐ No

Patient Name:_____ **Date of visit:**_____

Review of Systems: Do YOU have: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ Loss of Hearing
☐ Sense of ear blockage
☐ Facial weakness
☐ Ringing in ears/tinnitus
☐ Ear pain
☐ Previous ear surgery
☐ Dizziness/vertigo
☐ Ear drainage
☐ Exposure to loud noise
☐ Hearing aids
☐ Family history of hearing loss

☐ Nose bleeds
☐ Loss of sense of smell
☐ Sinus problems
☐ Nasal congestion/obstruction
☐ Nasal polyps
☐ Facial pain
☐ Nasal discharge
☐ Concern about nasal appearance
☐ Post nasal drip

☐ Recurrent sore throats
☐ Neck swelling/mass
☐ Hoarseness
☐ Neck infections
☐ Trouble/pain with swallowing
☐ Thyroid disease/nodule/goiter

☐ Chest pain/pressure
☐ Shortness of breath
☐ Cough
☐ Wheezing

☐ Abdominal pain
☐ Nausea/vomiting
☐ Diarrhea
☐ Problems with urination
☐ Constipation
☐ Heartburn/indigestion

☐ Seizures
☐ History of migraines
☐ Numbness
☐ Vision problems
☐ Paralysis
☐ Headaches

☐ Anemia
☐ Easy bleeding or bruising
☐ Fevers
☐ Unexplained weight loss

☐ Joint pain
☐ Muscle weakness
☐ Osteoporosis

☐ Skin disorders/diseases

☐ Second hand smoke exposure

FEMALE PATIENTS: Are you pregnant? ☐ No ☐ Yes (Number of weeks:)

Tests and studies: Have you had any tests or studies relevant to today's visit? If yes, please note these below:

Test **Hospital where test was performed**

☐ XRAY/CT/MRI _____ → Part of body (e.g. sinuses, adenoids, ears, neck, etc.):

_____

☐ Neck/Thyroid Ultrasound _____

☐ Thyroid blood tests _____

☐ Swallowing study _____

☐ Hearing test(s) _____

☐ Allergy tests _____

☐ Biopsies of the ear, nose, throat, face, or neck _____

Please list any other pertinent medical information that may be helpful to the doctor, as well as any other concerns you would like addressed during your office visit:

Bjorn Bie, M.D.
Eric Stein, M.D.
Arthur Lauretano, M.D.
Vijay Nayak, M.D.
Jessica Hootnick, M.D.
Vishnu Kannabiran, M.D.
Scott Finlay, M.D.
Katherine Nickley, M.D.
Ashley Swanson, PA-C

MASSACHUSETTS
EAR, NOSE AND THROAT ASSOCIATES

3 Meetinghouse Road
Chelmsford, MA 01824
280 Main Street
Suite 140
Nashua, NH 03060
Phones: (978) 256-5557
(603) 594-3025
Fax: (978) 256-1835
www.massent.com

PATIENT COMMUNICATION CONSENT FORM

Patient Name _____ Date of Birth_____

Parent/Guardian Name_____

I agree to allow Massachusetts Ear, Nose and Throat Associates to contact me in the following methods regarding my private health information, treatment, appointment reminders and other notification regarding my care .

Home Phone _____Yes _____ No **Cell Phone** _____Yes _____ No

Text Messages _____Yes _____ No **Email** _____Yes _____ No

Patient Portal _____Yes _____ No

I also authorize Massachusetts Ear, Nose and Throat Associates to access my Pharmacy record electronically for an updated medication list.
_____Yes _____ No

CHECK ONE:

_____ I authorize _____ to receive information on my behalf via above communication and in the exam room with the provider. Relationship to patient (circle one):

Parent Child Spouse Grandparent Grandchild Guardian Other

OR

_____ I DO NOT authorize Mass ENT to give information on my behalf to any person other than myself. (This does not include other medical practices, insurance companies, or any other entity addressed in the Hipaa agreement)

CONSENT TO HEALTH INFORMATION EXCHANGE:

I consent to allow my provider to use Health Information Exchanges (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to other healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

_____ _____
Patient/Authorized signature Date

By my signature below I acknowledge that I have read and understand the **Guidelines to Patient Communication** and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that may impose.

_____ _____
Patient/Authorized signature Date

Bjorn Bie, M.D.
Eric Stein, M.D.
Arthur Lauretano, M.D.
Vijay Nayak, M.D.
Jessica Hootnick, M.D.
Vishnu Kannabiran, M.D.
Scott Finlay, M.D.
Katherine Nickley, M.D.
Ashley Swanson, PA-C

MASSACHUSETTS
EAR, NOSE AND THROAT ASSOCIATES

3 Meetinghouse Road
Chelmsford, MA 01824
280 Main Street
Suite 140
Nashua, NH 03060
Phones: (978) 256-5557
(603) 594-3025
Fax: (978) 256-1835
www.massent.com

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- You must have your insurance card with you for each appointment.
- Patients with insurance, with which we are participating/contracted with:
  - Copayments, deductibles, and co-insurance amounts are due at the time of service.
- Patients with Insurance that requires a referral from a Primary Care Physician:
  - Referrals must be in place on the date of service. Without this referral in place, full payment or rescheduling would be required. If no referral is in place, your options are as follows:
    - Reschedule your appointment.
    - Pay for the visit (minimum of $250). This money will be refunded to you as soon as a referral is obtained.
- Patients with no insurance or non-participating/contracted insurance:
  - Payment is due at the visit, upon your check in. For new patients, we require a minimum payment of $250. If the balance is different than this, upon your checkout, we will either set up a payment plan for you, or refund you the difference.
- Non Emergent Care will be denied if:
  - A minor under eighteen is unaccompanied by an adult.
  - A referral is not obtained when required by the patient's insurance, and the patient refuses to pay for the visit.
  - A patient has been delinquent on back payments and/or the account has been sent to a third party collections institution.
  - A patient has been previously discharged from the office.

I hereby authorize Mass ENT Associates to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company and/or attorney, from PIP benefits or settlement proceeds, be made to Mass ENT Associates.

I understand that my insurance carrier may require a referral from my Primary Care Physician as authorization for treatment. It is my responsibility to obtain this referral. If a claim is denied by my insurance carrier for failure to obtain a referral, I will be held responsible for the full balance of the claim.

I permit a copy of this form to be used in the place of the original.

I have read and understand the conditions for payment to Mass ENT Associates and my responsibilities as outlined above.

Name:_____ Date:_____

HIPAA Notice of Privacy Practices
Mass ENT Associates
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact: Paulette Ladebauche.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information"(will be referred to as PHI throughout this document) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website (www.massentassoc.com), calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1.Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based upon your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your PHI for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to another physician who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose protected health information, as necessary, to provide you with information treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice, the services we offer and reminder post card. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected information that is relevant to your health will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happen your physician shall try to obtain your consent as soon as reasonable possible after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Disease: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products: to enable product recalls: to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of a practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security intelligence activities, including for the provision of protective services to the President or other legally authorized.

Worker's Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI. Depending on the circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part or your PHI not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting it in writing to our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to have your physician amend your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Paulette Ladebauche at 978-256-5557 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

Revised, January 8, 2016

Bjorn Bie, M.D.
Eric Stein, M.D.
Arthur Lauretano, M.D.
Vijay Nayak, M.D.
Jessica Hootnick, M.D.
Vishnu Kannabiran, M.D.
Scott Finlay, M.D.
Katherine Nickley, M.D.
Ashley Swanson, PA-C

MASSACHUSETTS
EAR, NOSE AND THROAT ASSOCIATES

3 Meetinghouse Road
Chelmsford, MA 01824
280 Main Street
Suite 140
Nashua, NH 03060
Phones: (978) 256-5557
(603) 594-3025
Fax: (978) 256-1835
www.massent.com

INSURANCE INFORMATION SHEET

Referring Doctor_____

Patient's Social Security Number_____

Primary Insurance Information

Insurance Carrier_____

Subscriber Name_____
Relation to Patient (circle one): Self Spouse Father Mother Child Guardian

Subscriber Social Security Number_____

Subscriber Date of Birth_____

Subscriber Employer_____

Secondary Insurance Information

Insurance Carrier_____

Subscriber Name_____

Relation to Patient(circle one): Self Spouse Father Mother Child Guardian

Subscriber Social Security Number_____

Subscriber Date of Birth_____

Subscriber Employer_____

Neither patient nor provider will make recording of office visits without the mutual consent of both parties

I acknowledge having received a copy of the practices' Notice of Privacy Practices.

Signature Date

MASSACHUSETTS
EAR, NOSE AND THROAT ASSOCIATES

3 Meetinghouse Road, Chelmsford, MA, 01824 or 280 Main Street, Suite 140, Nashua, NH 03060
Telephone: 978-256-5557 or 603-594-3025 Fax: 978-256-1835

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize **Mass ENT Associates** to use, disclose, or release my protected health information (medical records) to:

Name/Entity: _____

Address: _____ City: _____ State: _____ Zip: _____

Hold for pick up Mail Copies: Fax to: _____

Purpose of Request: (Please Circle) Personal Continuing Care Insurance Legal Transfer

Other: _____

Health and Personal Information to be released:
Please describe the information you want **Mass ENT Associates** to release, please include dates and details:

_____

_____

Permission about Specific Health Information: Only if you CHOOSE to share any of the following information, please write your initials on the line:

_____ I specifically give permission, as required by state law, to share information in my record about **HIV antibody and Antigen testing, and HIV/AIDS diagnosis** or treatment._____ I specifically give permission, as required by state law, to share information in my record about my **Sexually Transmitted Diseases**.
_____ I specifically give permission, as required by state law, to share information in my record about my **Genetic** information.
_____ I specifically give permission to share information in my record about A**lcohol or Drug treatment**. If this information is shared, I understand that a specific notice, required by state law, shall be included prohibiting the re-disclosure of this confidential information.

Signature - *Please sign and date this form:*

_____ _____

Patient's Signature Date

_____ _____

Parent/Legal Recognized Representative Signature Date

This Authorization to share my information is valid until (Date) _____.If I do not list a date, this permission will last for one year from the signed date. I understand that I can revoke this Authorization at any time by providing a written statement to **Mass ENT Associates** EXCEPT to the extent that the action is already done. By my signature I attest that I am legally recognized representative of the above mentioned patient in accordance with the following _____. The information release pursuant to this Authorization may be disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Mass ENT Associates will not condition treatment on payment of the provision of this Authorization.