NAPERVILLE EAR NOSE & THROAT ASSOCIATES, LTD.

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

_____ _____
Name of Patient/Previous Names | Birth Date/Medical Record Number

_____ _____
Street Address | City, State, Zip

Authorizes: | **Release Of Protected Health Information To:**

_____ _____
Name of Health Care Provider/Plan/Other | Name of Health Care Provider/Plan/Other

_____ _____
Street Address | Street Address

_____ _____
City, State, Zip Code | City, State, Zip Code

Information To Be Released:

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Allergy Records
___ Consultations
___ Surgical Reports
___ Hospital Records Including Reports
___ Laboratory Reports
___ Entire Record
___ Immunizations
___ X-Ray Reports
___ Prescriptions
___ Other (Specify): _____

Purpose For Need of Disclosure: (Check applicable categories)

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Legal Investigation or Action
___ Changing Physicians
___ Personal
___ Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Rights With Respect to This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting _____. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization –** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization –** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: _____. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/ or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: _____ **Date:** _____
(If signed by other than patient, state relationship and authority to do so.)

Witness: _____