Mann Ear Nose and Throat Clinic, PA **Authorization to RELEASE Health Information**

Patient Information:

Patient Name: _____DOB:_____

Address: _____

City-State, Zip: _____Phone: _____

At my request, _____ may release the following information:
(name of entity)

- ☐ Entire Record
- ☐ Lab Results
- ☐ Allergy Tests
- ☐ Audio Test
- ☐ Sleep Studies
- ☐ Operative Reports
- ☐ Radiology Results
- ☐ Financial Records
- ☐ Current Visits

☐ Other as listed _____

*Financial compensation is received for the communication

Entity or person who will receive the information:

Name: _____

Address: _____

City, State, Zip: _____Phone: _____

☐ **Send the information electronically. Email address**: _____

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be Accessed inappropriately. I still elect to move forward to allow email communication to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)