The Mann Ear, Nose & Throat Clinic
Est. 1991

HIPAA RELEASE OF INFORMATION AUTHORIZATION

Consent for access to Protected Health Information:

I give consent to the staff at Mann ENT Clinic to communicate with the person(s) listed below regarding my medical treatment. I consent to the use of my protected Health Care Information when communicating with the person(s) below. Mann ENT Clinic may communicate in person, by telephone, mail, e-mail, fax, or other means. I may withdraw this consent at any time by notifying Mann ENT Clinic in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Signature_____ **Date** _____

PLEASE LIST NAMES OF PERSONS OR FAMILY YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU.

Name: _____ Relationship: _____

Name: _____ Relationship_____

Name: _____ Relationship_____

Patient Rights:

- I have the right to revoke this authorization at any time in person or in writing
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases when 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 re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to 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 or a diagnosis related to mental health or substance abuse.

REVOKED
How: □ in person on _____ (Date) If in person, signature is required.
Signature of Patient or Personal Representative: _____

□ in writing

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