AUTHORIZATION
FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Completion of this form by the Patient authorizes the release of Protected Health Information, pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes EAR, NOSE & THROAT CONSULTANTS OF NEVADA ("Provider") to release the following information: (Describe specifically) _____
_____

2. The information may be disclosed by employees or business associates of Provider.

3. The information may be disclosed to: (Specific Name or Identification of the persons or entities to which the disclosure will be made – (**Please check one and provide all information needed to process**).

4. ☐ Please Mail To:_____

5. ☐ Please call when ready: (_____)_____-_____

6. ☐ Please Fax To: (_____)_____-_____ Attn:_____

7. The disclosure may be made for the following purpose. (Describe specifically. If disclosure is at the Patient's request, "At request of patient" will suffice) _____

8. This authorization will expire on _____ or when _____

_____ (describe occurrence).

9. I acknowledge: (i) that I have the right to revoke the authorization at any time; and (ii) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

   You may revoke this authorization only in writing, sent by certified mail to Ear, Nose & Throat Consultants of Nevada at the address below. The revocation will be effective only upon receipt, except (1) to the extent the Provider has acted in reliance on the authorization; or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

10. I understand that treatment by the Provider is not condition on my signed this authorization, although exceptions will be made for (a) research-related treatment; (b) for treatment for creating protected health information for a third party, such as pre-employment physicals; and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is condition on an authorization to use PHI to determine payment.

_____ _____ _____
PRINT Patient Name Signed by: Date

If person signing is other than patient, state authority under which signature is made.

Patient Date of Birth: _____ Patient Social Security Number: _____

Patient Account Number: _____

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