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EAR, NOSE, AND THROAT
CENTER

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Missouri Ear, Nose and Throat Center to obtain, use and/or disclose certain protected health information about me To/From:

_____
Doctor/Hospital/Clinic

_____
Address Phone Fax

_____
Patient's Name DOB SS#

This authorization permits Missouri Ear, Nose and Throat Center to use and/or disclose the following individually identifiable health information about me:

Operative Reports Laboratory Reports History & Physical Discharge Summary

Radiology Reports Entire Med. Record Pathology Slides Radiology Films

Specific Information: _____

This information will be used or disclosed for the purpose: _____

This purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire _____

I do not have to sign this authorization in order to receive treatment from Missouri Ear, Nose and Throat Center. In fact, I have the right to refuse to sign this authorization, it may be subject to resdisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at Missouri Ear, Nose and Throat Center.

_____
Signature of Patient or Guardian Date

_____
Print Patient's Name Signature of Witness/Date