Topeka ear nose & throat

Authorization for Disclosure of Protected Health Information (PHI)

PATIENT NAME: ______________________ **BIRTHDATE:** ______________

FULL ADDRESS: ______________________

EMAIL ADDRESS: ______________________

I hereby authorize disclosure of personal health information (PHI) concerning the above-named person.

FROM: ______________________ **PHONE:** ______________

ADDRESS: ______________________ **FAX:** ______________

TO: ______________________ **PHONE:** ______________

VIA MAIL: ______________________ **VIA FAX:** ______________

METHOD: ☐ Printed on paper ☐ Electronically uploaded to disc ☐ In-person pick up ☐ Mailed ☐ Emailed

☐ Progress Notes	**FOR TREATMENT DATES:**
☐ Test Results	______________________
☐ Billing Records	☐ Other: ______________________
☐ Demographic Information	______________________
☐ Entire Record	______________________

Entire Record will not include billing records or records not prepared by or on behalf of Topeka Ear Nose & Throat, P.A., unless those items are also selected.

My signature below indicates my understanding that:

- My records may contain information relating to the diagnosis or treatment of HIV, AIDS or other sexually transmitted diseases, alcohol and/or drug abuse, psychiatric treatment, emotional condition or mental illness.
- Federal regulations may protect my records, including information relating to psychiatric treatment or alcohol/drug use.
- This release shall be valid for one year from the date of signature, unless specified otherwise.
- I may revoke this consent at any time, with exception where legal action (e.g. probation, parole, etc.) relies upon it.
- Fees may be charged for the routinely duplicated production of medical records.

______________________ ______________

Signature of Individual Date

OR

______________________ ______________ ______________

Signature of Individual Representative Relationship to patient Date

______________________ ______________

Witness Date