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Authorization to Disclose Protected Health Information

In order to provide for your healthcare, **North Valley E.N.T. Associates, P.C.** maintains record of physical examinations, test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

This authorization gives **North Valley E.N.T. Associates, P.C.** permission to disclose the elements of my protected health information listed below for the purposes of continued medical treatment, unless otherwise stated by the requesting party.

I UNDERSTAND THAT THERE WILL BE A NOMINAL ADMINISTRATIVE CHARGE OF \$30.00 FOR PERSONAL RECEIPT OF ANY COPIES OF MY MEDICAL RECORDS BEYOND MY FIRST REQUEST.

NAME OF PATIENT: _____ **DATE OF BIRTH OF PATIENT:** _____

North Valley E.N.T. Associates, P.C. may disclose the following health information:

- All Records
- Radiograph Reports
- Lab Reports
- Office Visit Notes
- Other – Please Specify: _____

Purpose for which the authorization is being requested: _____

The health information requested is to be disclosed to VIA (Check One): MAIL FAX PICK-UP

Recipient _____

Address _____

City _____ State _____ Zip _____

FAX: _____ Phone: _____

This authorization will remain valid until ____/____/20____ or until the following event related to this authorization takes place: _____, after which time it will become invalid.

I understand that I may revoke this authorization in writing at any time, but that this revocation will not affect any prior authorized disclosures that have been taken by **North Valley E.N.T. Associates, P.C.**

Signature of Patient
Or Personal Representative

____/____/20____
Date

Printed Name & Relationship to
Patient (*if not self*)