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Authorization to Disclose My Health Information

Name of Patient: _____ DOB of Patient: _____

I Authorize: _____
(Name of doctor / facility / office)

Address: _____
Street City, State Zip Code

Phone #: () _____ Fax #: () _____

Patient name _____ Date of Birth: _____

Previous name (if applicable): _____

Authorization to disclose the following health care information (check all that apply):

- All Records
My health information for the date(s):
Other:

Please disclose this health information to:

North Valley Ear, Nose and Throat Associates, P.C.
3805 East Bell Road, Suite 5800, Phoenix, AZ 85032
Phone: (602) 688-6500
Fax: (602) 867-3144

This authorization will expire on: ____/____/20____.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

Patient or Authorized Individual Signature _____ Date (mm/dd/yyyy) _____

Printed Name _____ Relationship _____