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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. (NVENT)** 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 **NVENT** 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 \$50.00 FOR PERSONAL RECEIPT OF ANY COPIES OF MY MEDICAL RECORDS BEYOND MY 1ST REQUEST. \_\_\_\_\_ (INITIALS) \*\*YOUR OFFICE VISIT NOTES ARE ALWAYS AVAILABLE TO YOU IN THE PATIENT PORTAL AND CAN BE OBTAINED FREE OF CHARGE.**

**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 via (check one): MAIL FAX EMAIL PICK-UP

Recipient \_\_\_\_\_

Email \_\_\_\_\_

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*)