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### Authorization to Disclose Protected Health Information to Family and Friends

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

I hereby authorize North Valley Ear, Nose & Throat PC (NVENT) to discuss and/or release my protected health and billing information (PHI) to the individual(s) below (verbally, electronically, or written/printed). I understand I may revoke this authorization at any time by notifying NVENT.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

I acknowledge that information shared under this authorization to the recipient(s) listed above may be disclosed again by the recipient(s), and if that happens, it will no longer be protected by HIPAA.

\_\_\_\_ I decline to authorize any family member(s) or friend(s) to access my PHI.

\_\_\_\_\_  
Signature Printed Name Date