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GrandRapidsENT
ear • nose • throat

FACIAL PLASTIC & COSMETIC SURGERY

ALLERGY TESTING & TREATMENT

HEARING AID SALES & SERVICE

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION

From: _____
Person/entity to disclose this information
Address:
_____
Phone Number:
_____
Fax Number:
_____

To: _____
Person/entity authorized to receive this information
Address:
_____
Phone Number:
_____
Fax Number: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

☐ All information contained in my medical records (included but not limited to list below)

Specify date range , if applicable _____

OR

☐ ONLY the specific information checked below:

- ☐ Office/Consultation notes (specify date: _____)
- ☐ CT/MRI/Radiology Reports (specify date: _____)
- ☐ Operative/ER Reports (specify date: _____)
- ☐ Lab/Pathology Reports (specify date: _____)
- ☐ Allergy Testing Results (specify date: _____)
- ☐ Other _____

I acknowledge that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed by them and no longer protected by the privacy regulations. I acknowledge that I may revoke this authorization in writing at any time by contacting the disclosing party (Grand Rapids Ear, Nose, and Throat PC or other entity. This authorization expires six months after the date signed.

_____ _____
Signature of Patient/Legal Guardian or Personal Representative Date
Name of Personal Representative and Relationship to Patient