AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, **[name of patient]** _____ [**Date of Birth**] ____/____/____, authorize **[name and address]** _____ to use and/or disclose my health information as identified below to **St. Joseph's Ear, Nose & Throat Clinic, PLLC.** for the following purpose(s): **[describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual"]** _____ _____.

By **initialing** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ Complete Medical Record
_____ Imaging Reports
_____ Office Visit Notes
_____ Operative Reports
_____ Laboratory/Pathology Reports
_____ Billing Statements
_____ Specific Dates(s) of Service _____
_____ Other _____

***** _____ (**initial**) I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, genetic records, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to St. Joseph's Ear, Nose & Throat Clinic Medical Records Clerk. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon **[insert applicable date or event of expiration]** _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative — Date

_____ _____
Print Name of Legal Representative (if applicable) — Relationship of Legal Representative to Individual