Oakdale *ear, nose & throat* Clinic

Authorization to Communicate Protected Health Information

This form authorizes Oakdale Ear, Nose & Throat Clinic to discuss/review patient healthcare information with designated individuals.

Patient Name: _____ Date of Birth: _____

I request and authorize Oakdale Ear, Nose & Throat Clinic to release/discuss my healthcare information to:

Name(s)/Relationship(s) _____

_____

_____

Information disclosed for the following purpose:

- ❑ Continuation of care
- ❑ Insurance claim
- ❑ Patient access
- ❑ Litigation
- ❑ Other: _____

Information authorized for disclosure:

- ❑ Medical record (includes all listed below)
- ❑ Discharge summary
- ❑ History and physical
- ❑ Lab reports (past two years)
- ❑ Consultations
- ❑ Audiology
- ❑ Chart notes (past two years)
- ❑ Emergency department report
- ❑ Operative/Pathology report
- ❑ X-ray/CT/MRI (past two years)
- ❑ Allergy
- ❑ Other: _____

Specific dates of service: _____

- This authorization expires in one year.
- The designated record set may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, child abuse, or alcohol/drug abuse treatment.
- This authorization may be revoked at any time if done in writing and presented to Patient Services.
- Revocation will not apply to information already disclosed with this authorization for disclosure and/or information disclosed for purposes of treatment, payment and health care operations.
- Refusal to sign this authorization for disclosure will not affect treatment.
- You may inspect or copy the information for use or disclosure with this Authorization of Disclosure.
- Authorized disclosure of information may be subject to unauthorized re-disclosure.

Signature/Parent or Legal Guardian: _____ Date: _____