Wake ENT

Ear, Nose and Throat Specialists

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____

Printed Patient Name Date of Birth

Wake Ear Nose and Throat Specialist are authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: (Initial each entity/person you approve to receive information.)	Description of information to be released: (Initial each item that can be given to the entity/person on the left in the same section.)
_____**Answering Machine/Voice Mail** Telephone Number to call: Home Work Cell (Circle One)	_____Request to bring specific medical information _____Instructions to follow for visit/procedure _____Notification of surgery/procedure: Scheduled/Approved _____To request and/or give you additional specific information _____Appointment Reminders _____Other:_____ _____Leave any/all information on my answering machine/voicemail
_____**Email** Email Address:	_____Request to bring specific medical information _____Instructions to follow for visit/procedure _____Notification of surgery/procedure: Scheduled/Approved _____To request and/or give you additional specific information _____Appointment Reminders _____Other:_____ _____Leave any/all information on my answering machine/voicemail
_____**Post Surgery**	_____Post surgical status report
_____**Person(s)- Name & Relationship**	___Medical ___Exceptions:_____ ___Other:_____
_____***All of the Above***	
_____***None of the Above***	
Please list anyone whom we are not allowed to speak with in regards to your medical condition	

Patient Rights: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the front office coordinator. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective from date of receipt by Wake Ear Nose and Throat Specialist, I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by me.

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Witness Date