AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize workforce members of Pinon Hills ENT. to disclose information from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

This authorization is valid covering the period(s):

From (*date*) _____ to (*date*) _____

From (*date*) _____ to (*date*) _____

From (*date*) _____ to (*date*) _____

Information that I authorize to be disclosed _____

_____

_____

This information is to be disclosed to:

_____ _____

Name of Entity Receiving Information

_____ _____

Address *Phone*

The information is to be disclosed for the following purposes:

- ☐ At my request
- ☐ Other (please specify): _____

_____

I understand that: Pinon Hills ENT may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization .

- ☐ **Pinon Hills ENT** may condition my treatment, enrollment in the health plan or eligibility for benefits if I refuse to sign this authorization.

I understand that my health information may potentially be re-disclosed by the recipient identified in this authorization. **Pinon Hills ENT** is not responsible for any such disclosures **Pinon Hills ENT** and its workforce are released from any legal responsibility or liability for disclosures made pursuant to this authorization.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless revoked, this authorization will expire on the following date, event or condition: _____

_____ _____

Signature of Patient or Legal Representative *Date*

Description of authority of Representative to act on behalf of the patient: _____

_____