

Associates in Otolaryngology
48 Elm Street
Worcester, MA 01609
AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

1. I authorize Associates in Otolaryngology to use and/or disclose the following protected health information (PHI) from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: _____ Date of Birth: _____

Address: _____

3. Information to be disclosed to: _____

Name

Address

City

State

Zip

4. Disclose the following information for treatment dates: _____ to _____

Complete Records

Reports (X-Ray, MRI, CT)

Demographic Info

Progress Notes

Audio Reports

Lab Results

Health History

Operative Reports

Discharge Summary

Consult Reports

Sleep Studies

Other Specified: _____

5. The above information is disclosed for the following purposes:

Medical Care

Legal

Insurance

Other

6. I understand I may revoke this authorization at any time by requesting such of the above referenced physician practice in writing, unless action has been already taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires on (upon) _____
Date

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Name of Patient or Legal Guardian Date

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. IMPORTANT: AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL OF THE ABOVE ENTRIES ARE COMPLETED