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 confidentially.

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