SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Previous Name(s): _____

I authorize Southwest Idaho ENT and Surgery Center to use or disclose protected health information (PHI) contained in my medical records in the following manner:

FROM _____
Physician/Institution that currently has records

_____
Street Address

_____
City State Zip Phone Fax

TO _____
Physician/Institution/individual requesting records

_____
Street Address

_____
City State Zip Phone Fax

Release the following protected health information. *(Patients who request more than the last two years of their records may be charged a $10 service fee. All payments are required prior to copying. All records are burned to a CD, faxed or emailed. If paper copies are requested, there will be additional charges.)*

☐ All Records
☐ X-Ray/Diagnostic Report(s)
☐ Chart Notes
☐ Discharge Summary
☐ Operative Report(s)
☐ Labs/Pathology Report(s)
☐ Medical Bills
☐ Other: _____

Reason for Authorization: _____

☐ Expiration Date: _____ OR ☐ Event (one-time release): _____

☐ Pickup Location: _____ ☐ Faxed ☐ Mailed ☐ Emailed to: _____

I understand that if the person or entity that received the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for the purpose of treatment or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized Southwest Idaho ENT and Surgery Center to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original. I understand that I may revoke this authorization in writing at any time to Southwest Idaho ENT and Surgery Center, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol and drug abuse. My signature below authorizes the release of all such information unless I have marked NO and initialed it.

_____ YES _____ NO _____ INITIALS

_____
Signature/Legally Responsible Party Relationship to Patient Date