Mid-Valley ENT & Allergy
ENT Hearing & Balance Center

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION

Name: ______________________________ Date Of Birth: ______________

Address: ______________________________

Phone: ______________________________ Social Security #: ______________

I authorize the office of Mid-Valley ENT & Allergy/Hearing & Balance Center to do the following:

☐ Provide Information To: ☐ Receive Information From:

Facility/Person	Facility/Person
Street Address City/State/Zip	Street Address City/State/Zip

This information will be used on my behalf for the following purpose(s):

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INFORMATION TO BE DISCLOSED:

☐ Entire Chart ☐ All Chart Notes ☐ History & Physical ☐ Operative Reports

☐ Lab/Pathology Reports ☐ Imaging Reports ☐ Other Records as Specified: ______________

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☐ Specific Dates of Treatment: ______________________________

Drugs and/or Alcohol Abuse and/or Psychological and/or HIV/AIDS Records Release:
I understand that my medical or billing records may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and or other sensitive information. I agree to its release.

Time Limit and Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization at any time, I can revoke this authorization by submitting a notice in writing to the facility at the above address. Unless revoked, this authorization will expire on the following date or event ______________________, or one year from date of signature, unless otherwise specified.

Redisclosure
I understand that once information is released to the above-named person or persons, my information may be subject to redisclosure and no longer protected by the Federal Privacy Regulations. I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party.

I authorize Mid-Valley ENT & Allergy to use and disclose the protected health information as specified above.

I understand that if I authorize the release of Drug and Alcohol Abuse Treatment records that those records are protected by Federal Law. The authorization for Release of Information Form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law for alcohol/drug abuse prohibits information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations.

______________________________ ______________

Signature of Patient/Authorized Representative or Responsibly Party Date

______________________________ ______________

Printed Name of Patient/Authorized Representative or Responsibly Party Date

FAX: 541-967-6548
midvalleyentallergyandhearing.com

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950 29th Ave. SW
Albany, OR 97321
PHONE: 541-967-0404

Newport Clinic:
1010 SW Hwy. 101
Newport, OR 97365
PHONE: 541-967-0331