Ear, Nose and Throat Associates
Patient Authorization to Disclose, Release and/or Obtain Protected Health Information
Records to be Released or Disclosed

1. Patient Information:

Full Name: ____________________ ENT Chart: ____________________

Address: ____________________

DOB: ____________________ Phone ( ) ____________________

2. Purpose or need for disclosure – may be released electronically (Please check all applicable categories)

☐ Employer ☐ Insurance ☐ Attorney ☐ School ☐ Self

☐ Medical Provider ☐ Disability ☐ Other Specify:

3. Name of person or facility that records are to be disclosed to:

Name ____________________ Phone: ( ) ____________________ Fax: ( ) ____________________

Email: ____________________

Address: ____________________

4. Type of records to be disclosed:

Comprehensive overview of chart:
☐ Clinic summaries including treatment notes, history & physical ☐ Operative notes
☐ Pathology reports ☐ Radiology/diagnostic reports, lab reports
☐ Hearing/Audiology notes
☐ Billing claim summaries (including third party payers and patient payments)

From Date: ____________________ **To Date:** ____________________

*If timeframe is not specified, most recent three (3) years of medical records will be provided

☐ Specific summary or report: ____________________

☐ Audiology: ☐ Most recent hearing test only, single visit
☐ All previous hearing test(s) multiple visits ☐ All audiology related treatment notes and testing

AND/OR: I authorize VERBAL COMMUNICATION ONLY about my medical history and care.
☐ Checking this box means no physical records will be sent unless otherwise indicated.

5. Format to be sent: ☐ Paper mail ☐ Fax ☐ Email ☐ Verbal ☐ Picked up in office

6. This authorization is valid for three (3) years from the date on which it is signed unless otherwise indicated below: I understand that I have the right to revoke this authorization at any time, except to the extent that the information has been released in accordance of this authorization.

In effect until this date: ____________________

Or when the following event occurs: ____________________

____________________ Date: ____________________

Signature of Patient or Legally Authorized Representative (above)

Name and Relationship of Legally Authorized Representative to Patient (below) ☐ POA or Guardianship law

Please Print: ____________________ Relationship: ____________________

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Instructions for Completing Patient Authorization to Disclose, Release or Obtain Protected Health Information (PHI)
By signing this document, I acknowledge that I have read and agree to the terms of this form.

Minors: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

Patient Rights: I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to ENT Associates 128 Lilly Road NE Suite 202 Olympia WA 98506.

I understand I have the following rights to:

- Inspect or to receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I also understand ENT Associates will not base treatment or payment decisions on receipt of this signed authorization.

This authorization form can be sent to us by mail or by fax. If the patient chooses to accept the risks associated with unencrypted email (that email communications could potentially be read by a third party), the form may be sent by email: info@entsw.com

Please be advised that you will be provided with a copy of records that were requested and authorized as of the date of the authorization. These records will be generated from the Legal Health Record which in some instances involves a hybrid record which may contain some paper as well as data and medical information and treatment records from multiple electronic health record systems. With electronic health information being created and generated in real time by multiple users we do our best to ensure the record provided to you contains all the documentation entered by the clinicians involved in the patient's care. If you should feel that you did not receive a complete set of the information requested, please feel free to reach out to our office by contacting 360-357-6314 for assistance.

Item #6 (Expiration): if "Other expiration event" is selected, the event must be one that is related to the patient (example - termination of patient's treatment, patient's death) or to the purpose for the authorization (e.g., if the authorization is for disability determination, the authorization might end when the determination has been finalized). Ordinarily, a specific date is preferable. Signatures: In general, a patient age 18 or older has legal authority to sign this form. For patients younger than 18, generally the patient's parent or legal guardian must sign on behalf of the patient. There are many exceptions under Washington State law to these general rules. (Examples – The patient is permitted to sign this form regardless of age for disclosures of patient information related to reproductive health; If the patient is age 14 or older, the patient may authorize disclosure of HIV test results; If the patient is age 13 or older, the patient may authorize disclosure of outpatient mental health treatment.) For deceased patients, this form may be signed by the patient's surviving spouse or personal representative. All individuals signing for use or disclosure of medical information on behalf of a patient must state their relationship to the patient and may be required to provide proof of legal authority to permit the use or disclosure of the medical information.