AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that ENT Group of Los Angeles will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized permission, except as required by law.

PLEASE PRINT CLEARLY

Patient Name: ____
Last First MI Maiden

Date of Birth: ________________ Social Security Number: ______________________

Patient Address: ____
Street City State Zip Code

Daytime Phone:____________________ Evening Phone: __________________

I authorize ENT Group of Los Angeles

To release to ____
Name of the Physician, Facility, Other or Self Mailing Address (if applicable)

Fax Number: ____

The following information: (Please check and date)

( ) Entire Record:____________________
( ) Lab:____________________________
( ) X-ray:___________________________
( ) Other:___________________________
( ) Progress Notes:____________________
( ) Correspondence:____________________
( ) Records from other facilities:__________

Purpose of Disclosure: ( ) Medical Care ( ) Legal ( ) Insurance ( ) Personal ( ) School ( ) Work ( ) Other: ____________________

5525 Etiwanda Ave, Suite 211, Tarzana, CA 91356
Tel 818-609-0600 Fax 818-609-1680 staff@entgroupla.com

READ THE FOLLOWING CAREFULLY BEFORE SIGNING

By signing this form, I understand that I am authorizing the release or disclosure of the requested health information as marked above in accordance with any specifications I have made. I also understand that the health information to be released may include reference to treatment or history of**: 1) Mental or behavioral health, 2) Alcohol or drug abuse, 3) HIV and/or AIDS.**
**INITIAL THE SPACE PROVIDED IF YOU DO NOT AUTHORIZE THE RELEASE OR DISCLOSURE OF 1, 2, OR 3 ______________

I understand that this authorization will expire one (1) year from the date it is signed by the patient or legal representative, that it may only be used for the disclosure listed above and that it will become part of my medical record.

I understand that I may revoke this consent at any time with written request to be effective on the date notified except to the extent that action was already taken in reliance on this signed authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and would no longer be protected by the federal privacy regulations.

I understand that I may see and obtain a copy of the records described in this authorization upon my request. Additionally, I may receive a copy of this authorization upon my request.

I understand that ENT Group of Los Angeles may receive compensation for the use or disclosure listed on this authorization.

____	____________________
Patient's or Legal Representative's Signature	Date Signed
____	____________________
Printed Name of Patient's Representative	Relationship to Patient

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REVOCATION – SIGN THIS SECTION ONLY IF YOU WANT TO REVOKE THIS AUTHORIZATION

I hereby revoke this authorization.

____	____________________
Patient's or Legal Representative's Signature	Date Signed

OFFICE USE ONLY: Date form received: _________________________
Disclosure date: _____________________ Disclosed by: ___________________________