Geneva Woods Ear, Nose, and Throat Associates, Inc.

Phone: 907-563-3515 Fax: 907-563-3541

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

I authorize release of medical records from:

_____

_____

_____

Phone/fax:_____

To be released to:

_____

_____

_____

Phone/fax:_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such information or record exist:

___ Please send the entire medical record (all information) to the above named recipient
___ All hospital records (including nursing records and progress notes)
___ Medical records needed for continuity of care
___ Emergency and urgent care records
___ Diagnostic imaging reports
___ Clinician office chart notes
___ Billing statements
___ Laboratory reports
___ Pathology reports
___ Operative reports
___ Other:

_____

_____

****The following items must be initialed to be included in the use or disclosure of other health information:**

___ ** HIV/AIDS related information and/or records
___ ** Mental health information and/or records
___ ** Genetic testing information and/or records
___ ** Drug/alcohol diagnosis, treatment or referral information. (Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe:

_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal regulations, the information described above may be redisclosed and no longer protected under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I my refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, providing that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked in writing earlier, this authorization will expire 180 days from the date of signing.

_____ _____ _____

Patient or Legal Representative Sign | Printed name of signer | Date

_____ _____

Witness Signature | Date