Topeka ear nose & throat

Authorization for Disclosure of Protected Health Information (PHI)

PATIENT NAME: _____ **BIRTHDATE:** _____

FULL ADDRESS: _____

EMAIL ADDRESS: _____

I hereby authorize disclosure of personal health information (PHI) concerning the above-named person.

FROM: _____ **PHONE:** _____

ADDRESS: _____ **FAX:** _____

TO: _____ **PHONE:** _____

VIA MAIL: _____ **VIA FAX:** _____

METHOD: ☐ Printed on paper ☐ Electronically uploaded to disc ☐ In-person pick up ☐ Mailed ☐ Emailed

☐ Progress Notes ☐ Test Results ☐ Billing Records ☐ Demographic Information ☐ Entire Record	**FOR TREATMENT DATES:** _____ ☐ Other: _____ _____ _____

Entire Record will not include billing records or records not prepared by or on behalf of Topeka Ear Nose & Throat, P.A., unless those items are also selected.

My signature below indicates my understanding that:

- My records may contain information relating to the diagnosis or treatment of HIV, AIDS or other sexually transmitted diseases, alcohol and/or drug abuse, psychiatric treatment, emotional condition or mental illness.
- Federal regulations may protect my records, including information relating to psychiatric treatment or alcohol/drug use.
- This release shall be valid for one year from the date of signature, unless specified otherwise.
- I may revoke this consent at any time, with exception where legal action (e.g. probation, parole, etc.) relies upon it.
- Fees may be charged for the routinely duplicated production of medical records.

_____ _____

Signature of Individual | Date

OR

_____ _____ _____

Signature of Individual Representative | Relationship to patient | Date

_____ _____

Witness | Date

920 SW Lane St., Suite 200
Topeka, KS 66606
785-233-0500

1301 W 12th Ave., Suite 106
Emporia, KS 66801
620-340-0168

1106 St. Mary's Rd., Suite 303
Junction City, KS 66441
785-233-0500

www.topekaent.com