Ear Nose and Throat Associates of Central PA, PC

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize ____

To release the records of:

____ ______________________ **to**:

Patient's Name (Print First MI Last Name) Date of Birth

Ear Nose and Throat Associates of Central Pennsylvania, PC at the above address.

The purpose of the request is ___ Patient Care ___ Insurance ___ Workers Comp ___ Military

___ Disability ___ Patient Request ___ Other ____

Information to be released is: (Itemized portions of record and time period)

____

____

I authorize the inclusion of the following type of information, which I understand is specifically protected by federal/state statues:

____ HIV/AIDS information _____ Alcohol/drug treatment _____ Mental Health treatment

I understand that this consent if revocable by me, in writing, at any time except to the extent that action has been taken in reliance thereon. I will forward any such written request to revoke this consent to the Privacy Office. This consent is valid for 3 months or until ____________. I understand that authorizing this disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I can inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the receiving party.

____________________________________ ____

Date of Signature Patient's Signature

____________________________________ ____

Witness Signature of Responsible Party & Relationship