Ear Nose and Throat Associates of Central PA, PC

R. Charles Howells II, MD, FACS; Robert J. Caughey, MD; Kara E. Kimberly, MD; David E. Higgins, MD

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Dr. Howells, Dr. Caughey, Dr. Kimberly and/or Dr. Higgins to release the records of:

_____ _____ to:

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

_____

Name of Person or Organization

_____

Address

Fax to: _____

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. ____If checked, I understand that Drs. Howells, Caughey, Kimberly & Higgins will be reimbursed by the organization to whom the information is being sent for the purpose of coping and providing this information.

_____ _____

Date of Signature Patient's Signature

_____ _____

Witness Signature of Responsible Party & Relationship