SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

**PATIENT:** _____

**OTHER LAST NAMES:** _____

**SOCIAL SECURITY NO:** _____ **DOB:** _____

This document authorizes Southwest Idaho Ear Nose and Throat, P.A. (hereafter, "SWIENT") to release information regarding my medical condition to:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

The person or organization who receives this authorization has my consent to release/disclose protected health information in accordance with the other terms of this authorization. SWIENT may release medical records regarding my medical condition, in accordance with the other terms of this authorization, to a medical doctor, physician, surgeon, chiropractor, psychiatrist, psychologist, pharmacist, therapist, medical technician, hemophilia treatment center, nurse, consultant, osteopath, podiatrist, vocational rehabilitation specialist, dentist, hospital, health care clinic, alcohol and/or drug and/or substance abuse treatment center, pharmacy, laboratory or other health care specialist.

SWIENT is authorized to release all information regarding my medical condition—including, but not necessarily limited to, any and all documents, records, writings, reports, notes, correspondence, charts, billings, invoices, office charts, office reports, operative or surgical reports, emergency room records, outpatient department records, physical therapy records, radiology reports, radiology films, laboratory reports, pathology slides including accompanying pathology reports, progress notes, physicians' notes, physicians' orders, narrative summaries, nurses' notes, consultation reports, prescription records, medication charts, x-ray reports, CT scan reports, MRI reports, myelogram reports, vocational rehabilitation reports and thermographic reports—related to any examination, testing, evaluation, diagnosis, treatment, hospitalization, surgery, therapy, counseling, prognosis or other health care, service and/or supplies provided to me at any time with regard to any past, present or future mental, emotional, physical or medical disease, illness, impairment, disability, injury or other conditions.

SWIENT is authorized to release information regarding my medical condition, whether the information was initially prepared by SWIENT or by some other person or entity, even if the person or entity that prepared the information is not associated with or employed by SWIENT.



The purpose or need for the records are as follows: _____

_____

_____

I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization is valid for a period of one (1) year.

**SPECIFIC AUTHORIZATION**

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse. My signature below authorizes the release of all such information, unless I have marked "No" and initialed it.

☐ Yes ☐ No _____Initials

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Personal Representative (If Applicable) Relationship to Patient

This authorization conforms with the regulations promulgated pursuant to 164.508(c) of the Health Insurance Portability and Accountability Act (HIPAA).

This authorization also conforms with the regulations promulgated pursuant to Section 333 of the Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended, and Section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1972, as amended.

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STATE OF IDAHO
County of Ada

On this _____ day of _____ , 20____, before me, the undersigned personally appeared _____, its _____, known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed to the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

_____

Notary Public For: _____

My Commission Expires: _____



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