Greenville ENT

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be completed in its entirety in order to be considered valid.

Patient Name:____ Date of Birth: _______________________

Address: ____

Last 4 digits Social Security Number: _______________ Patient's Email Address: ______________________________

☐ **I authorize Greenville ENT, LLC to obtain information FROM:**

☐ **I authorize Greenville ENT, LLC to disclose/release information TO:**

Name of Individual/Organization: ____

Street Address: ____ **City:** ________________________________

State: _________ **Zip Code:** ________________ **Phone Number:** ______________________________________

Fax Number: ____ **(cannot fax to a residence)**

The purpose of the disclosure is:
☐ **Continued Care** ☐ **Legal** ☐ **Insurance** ☐ **Disability** ☐ **Patient Request** ☐ **Other:** ____________

Date(s) of service: _______________________________

For selections marked above please provide the date range that you would like to information from.

***Dates of treatment to be released**: From _______________ To ________________

Patient's Rights- I understand that:

- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information. I have a right to receive a copy of this form upon request.
- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- Greenville ENT will not share or use my health information without permission other than by ways listed in Greenville ENT Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.greenvilleent.com.

____ ____
Printed Name of Patient or Legal Guardian/Representative Date

____ ____
Signature of Patient or Legal Guardian/Representative Relationship to Patient, if signed by Legal Guardian