MIDWEST EAR, NOSE & THROAT SPECIALISTS MIDWEST ALLERGY & ASTHMA MIDWEST HEARING MIDWEST

Authorization to Share Protected Health Information (PHI)

I (patient/parent/legal guardian), _____ (print name), hereby authorize Midwest ENT Specialists to share PHI verbally or in writing with:

Person_____ Relationship:_____

-or-

Facility Name/Healthcare Provider:_____

Address: _____ City/State/Zip: _____

Phone: _____

Regarding:_____

Patient Name:_____ DOB:_____

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information shared. If not indicated, information will not be shared, released or obtained.

☐ Alcohol, Drug, Substance Abuse Records ☐ HIV/AIDS Testing/Treatment ☐ Psychiatric Evaluation/Treatment

☐ Genetic Records

Unless otherwise revoked, this authorization will expire ONE year from the date it is signed unless I specify an expiration date/event/condition here: Date _____/_____/_____ or specific event/condition_____

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Business Office at 215 Radio Drive, Suite 202, Woodbury, MN 55125.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization .
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Print Name Relationship to Patient (if applicable)

For Office Use Only: Account Number:_____ **Date received: _____**