MIDWEST EAR, NOSE & THROAT SPECIALISTS | MIDWEST ALLERGY & ASTHMA | MIDWEST HEARING | MIDWEST FACIAL PLASTIC SURGERY

Authorization to Share Protected Health Information (PHI)

Patient Name:_____ Account #:_____ DOB: _____

I (patient/parent/legal guardian), _____ hereby authorize Midwest ENT Specialists
(print name)

to share PHI verbally or in writing with:

Person_____ Relationship:_____

OR

Facility Name/Healthcare Provider:_____

Information for Authorized Person/Facility/Healthcare Provider:

Address: _____ City/State/Zip: _____

Phone: _____ Regarding:_____

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:
*Assigned Expiration Date if different from one year from today _____/_____/_____ or specific expiration 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 | Signature Date

_____ _____
Print Name | Relationship to Patient (if applicable)
