Ear, Nose & Throat Associates of Charleston, Inc. (EN&T)
Authorization for Use and Disclosure of Health Information

Patient:				
	Last Name	First Name	M. I.	Medical Record #

Birth Date:	Social Security #:

1.

☐ EN&T is authorized to SEND the above named individual's health information as described below to (name and address): ____________ ____________ ____________	____________ ____________ ____________ is authorized to SEND the above named individual's health information as described below to ATTN: Medical Records, Ear, Nose &Throat Associates of Charleston, Inc., PO Box 1628, Charleston, WV 25326-1628.

2. The description and amount of information to be used or disclosed is as follows: (include dates where appropriate). Mark only those choices that apply: ☐ Complete medical record ☐ Audiogram(s) ☐ Other ____________

3. The information may be used or disclosed for the following purposes: *(not required if requested by patient)* ____________ ____________

4. Please check if permitted to disclose records pertaining to:
   - ☐ Acquired immunodeficiency syndrome (AIDS)/Human immunodeficiency virus (HIV)
   - ☐ Behavioral or mental health services
   - ☐ Treatment for alcohol and drug abuse

5. This authorization is valid for a period of no more than six (6) months. If you wish an earlier expiration date, please specify date ____________.

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

7. I understand that I may inspect and receive a copy of this authorization.

8. I understand that EN&T will not refuse to treat me simply because I do not sign this authorization unless the healthcare is solely for the purpose of creating healthcare information for disclosure to a third party (i.e. pre-employment physical, disability, Worker's Compensation, or research-related care).

9. I understand that I may revoke this authorization at any time in writing, except where action has already been taken in reliance on this authorization or as stated in EN&T's Notice of Privacy Practices. An Authorization Revocation form must be completed and mailed to the Privacy Officer, Ear, Nose & Throat Associates, Post Office Box 1628, Charleston, WV 25326-1628.

10. Signing below indicates that you agree to release EN&T, its health care providers, officers, and other personnel from any legal responsibility or liability for disclosure of the above described information to the extent indicated and authorized herein; and have read this authorization and agree with its terms.

____________________________________ ____________________
Signature of patient or patient's representative *Date*

____________________________________ ____________________
Name of patient's representative (if applicable) *Relationship to the patient*

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