Princess Anne ENT & Allergy, PC.

828 Healthy Way, Suite 280, Virginia Beach, VA 23462

Authorization to Disclose Protected Health Information

Princess Anne ENT & Allergy, PC. is authorized to use or disclose the health information pertaining to:

Patient Name: ___________________________________ Date of Birth: _______________________
Daytime Phone Number: ____
Street Address: ____
City: _________________________________ State: _________ Zip Code: _____________________

The type and amount of information to be used or disclosed is as follows:

______ Physician/provider visit documentation
______ Laboratory results
______ X-ray reports
______ Audiogram results
Other: ____
____

The requested medical information may be disclosed to and used by the following individual or organization:
Name: *Princess Anne ENT & Allergy, PC.*
Address: *828 Healthy Way, Suite 280* City: *Virginia Beach* State: *VA* Zip: *23462*
For the Purpose of: *Sending and/or Requesting Medical Records*

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date: Month: __________ Day: _______ Year: __________.
If I fail to specify and expiration date, this authorization will expire in six (6) months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by Federal confidentiality rules.

______________________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________________ ______________________________
If signed by Legal Representative, Relationship to Patient Signature of Witness