Ear, Nose & Throat
Physicians & Surgeons, P.A.

Jeffrey B. Byer, M.D.
Richard H. Lee, M.D.
James Murray, M.D.
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AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION (PHI)

This authorization is for use or disclosure of protected health information pertaining to:

Name: ______________________________

Address: ______________________________

DOB: __________ ACCT: __________ Phone: __________

I hereby authorize the following health care provider:

_____ Ear, Nose, & Throat Physicians & Surgeons

_____ Advanced Hearing Center

To obtain my protected health information from:

Name: ______________________________

Address: ______________________________

Phone: __________ Fax __________

Purpose of Disclosure:

Protected health information to be released:

☐ Medical records (specify, can state "all"): __________

☐ Billing records

Time frame: ☐ entire record ☐ records from __________ (date) to __________ (date)

Your specific permission is required to disclose information regarding the following:

Check box and sign to specify protected health information to be disclosed

☐ Treatment by Mental Health Professional or Program __________

☐ Drug/Alcohol Abuse __________

☐ HIV Test Results or Status __________

Signed: ______________________________ **Date:** __________

Print name: ______________________________

If signed by other than patient, indicate legal relationship: __________