Authorization for Disclosure of Health Information

PATIENT:

Name:	Date of birth:
Street Address:	City/State/Zip code:

Authorizes:

Facility Name: _____
Street Address: _____
City/State/Zip Code: _____

To Release Health Information to:

DeFatta ENT & Facial Plastic Surgery
1490 Rivers Edge Trail
Altoona, WI 54720

Fax #: 715.839.7796

MEDICAL RECORDS AUTHORIZED TO BE RELEASED:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All Allergy records	☐ Allergy Serum	☐ All ENT (ears, nose, throat) records
☐ Surgical reports	☐ Radiology reports	☐ Medical History
☐ Hospital records	☐ Audiology records	☐ Other:

Records to be released for the following date(s): _____

PURPOSE FOR NEED OF DISCLOSURE:

☐ Continuation of Medical Care	☐ Insurance eligibility
☐ Personal	☐ Other:

I, the undersigned, understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes. Release of Psychotherapy Notes requires a separate authorization.**

I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

I understand that after my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that my authorization will remain effective from the date of my signature until (date) _____, and that the information will be handled confidentially in compliance with all applicable federal laws. I also understand that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

Signature of Patient/Guardian: _____Date: _____