AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
ENT Medical Center

Name of Patient:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:
Preferred Phone Number:	Alt. Phone Number:

I authorize the following to disclose the patient's protected health information:

Person/Organization Name: ENT Medical Center
Mailing Address: 5258 Dijon Drive
City, State, Zip Code: Baton Rouge, Louisiana 70808
Telephone Number: (225) 769-1090 Fax Number:_____
Relationship (if applicable):_____

❒ **TO RELEASE Information TO** **or** ❒ **TO OBTAIN Information FROM**

Person/Organization Name: _____
Mailing Address: _____
City, State, Zip Code: _____
Telephone Number: _____ Fax Number:_____
Relationship (if applicable):_____

REASON FOR DISCLOSURE
(Place an "X" in all boxes that apply.)

- ❒ **Treatment/Continuing Medical Care**
- ❒ **Personal Use**
- ❒ **Billing or Claims**
- ❒ **Insurance**
- ❒ **Eligibility Determination**
- ❒ **Legal Purposes**
- ❒ **Employment**
- ❒ **Disability Determination**
- ❒ **Changing Physicians**
- ❒ **School**
- ❒ **Research Related Treatment**
- ❒ **Other**_____

I authorize the release of the following protected health information. *(Place an "X"in all boxes that apply to the information you want released or obtained.)*

- ❒ All Health Information
- ❒ Medical History, Examination, Reports
- ❒ Consultation Reports
- ❒ Billing Information
- ❒ Surgical Reports
- ❒ Diagnostic Test Reports
- ❒ Hospital Records including Reports
- ❒ Other: _____
- ❒ Radiology Images
- ❒ Patient Allergies
- ❒ Immunizations

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

- ❒ Sexually Transmitted Diseases
- ❒ Mental Health (excluding Psychotherapy Notes)
- ❒ Psychotherapy Notes
- ❒ Drug/Alcohol/Substance Abuse
- ❒ Vocational Rehabilitation
- ❒ Other_____
- ❒ Genetics
- ❒ HIV (AIDS)

This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____.

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by ENT Medical Center. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature_____ _____
Signature of Individual or Individual's Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable):_____
If representative, specify relationship to the individual:

❒ Parent of minor ❒ Guardian ❒ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature_____ _____
Signature of Minor Individual Date