The Ear Center of Greensboro, P.A.
1126 N. Church Street, Suite 201
Greensboro, NC 27401
Phone: 336-273-9932 • Fax: 336-273-9936 • Web Site: www.earcentergreensboro.com

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION V. 2.0
Request for Release of Medical Records

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the physician/organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations.

I authorize **The Ear Center of Greensboro, P.A., its physician and employees**, to disclose the following information from the medical records of:

Patient Name: ____ Date of Birth:_________________ Patient Number:_____________
(Print)
Address: ____
(Print)
Telephone: (____)_______________________ Cell Phone:(____)____________________

Covering the period(s) of health care: From __________________________ to _________________________
(Date) (Date)

Information to be disclosed:
- ○ Complete health record(s), including all images (photographs, CT/MRI scans, etc.)
- ○ Complete health record(s), excluding all images

OR
Select from the following (check as many as apply):
- ○ History & Physical Examination
- ○ Progress Notes
- ○ Consultation Notes
- ○ Laboratory Tests
- ○ CT/MRI reports
- ○ Photographs, digital or other images
- ○ Operative Reports
- ○ Discharge Summaries
- ○ Mental health care or services
- ○ Psychotherapy Notes
- ○ Alcohol/Drug Treatment
- ○ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
- ○ Other (please specify) ____

This information is to be disclosed to the following individual or entity:
Name:____________________________________
Address: __________________________________
Telephone: (______)___________________________

For the purpose of:______________________________________
Relationship: (if any)_____________________________________
Fax: (______)________________

The patient or the patient's representative must read and initial the following statements:

A. I understand that unless earlier revoked, this authorization will expire in six months from the date of signing or by the date specified here: ______/______/______. Initials:___________

B. I understand that I may revoke this authorization at any time by notifying The Ear Center of Greensboro, P.A., in writing, but if I do revoke my authorization, it will not have any effect on any actions that The Ear Center of Greensboro, P.A. took before it received the revocation. Initials:___________

C. I understand that The Ear Center of Greensboro, P.A. cannot make me sign this authorization as a condition to receive treatment from The Ear Center of Greensboro, P.A., except as follows:
(i) when The Ear Center of Greensboro, P.A. provides me with research-related treatment, or

(ii) when The Ear Center of Greensboro, P.A. provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. Initials:___________

The Ear Center of Greensboro, P.A., its physician, officers, and employees (staff) are hereby released from any legal responsibility or liability for disclosure of the above information at my request or the request of my representative (hard copy, faxed, emailed, or other) to the extent indicated and authorized herein. Furthermore, I understand and accept that when I request that protected health information be faxed or emailed that: (1) the staff will not be encrypting faxes, (2) will not be held responsible for any faxed or emailed transmissions, (3) will be held harmless, and (4) will be indemnified by both the requester and intended receiving party for all risks, including but not limited to, any potential issues of confidentiality or privacy concerning any and all faxed or emailed correspondence. Emails will be sent as encrypted, passworded, .pdf files and may be printed. Our staff can register you for our **MyPortal web site** that will give you access to your records.

Form MUST be completed before signing.

_________________________________ _____________
Signature of Patient or Patient's Representative Date

____________________________________ ______________________________
Printed name of Patient or Patient's Representative Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient: ____
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