EASTERN CAROLINA ENT – HEAD AND NECK SURGERY, PA

850 Johns Hopkins Drive – PO Box 5007 – Greenville, NC 27835

Phone: (252) 752-5227   Fax: (252) 752-1191

Authorization to Use or Disclose Protected Health Information

Eastern Carolina Ear, Nose & Throat- Head & Neck Surgery, PA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Patient Name ____________ DOB ____________ SSN ____________

Address ____________

I hereby authorize Eastern Carolina ENT – Head and Neck Surgery, PA, or ____________

to disclose my medical records to the following:

Person/Facility ____________

Address and/or Fax number to which they are to be released ____________

Medical information requested to be released:

- ☐ All Records
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Other ____________

Expiration: Unless otherwise stated, this authorization will expire six months from the date this release is signed.

Signature of Patient or Legal Representative ____________ Date ____________

I understand that any disclosure of information carries with it the potential for re-disclosure, and that the information then may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.