Eastern Oklahoma Ear, Nose and Throat, Inc.

Authorization to Use or Disclose My Health Information

Patient Name: _____ Date of Birth: ___/___/_____ Chart #:_____

Any Previous Names _____

1. My Authorization

Eastern Oklahoma Ear, Nose & Throat, Inc. (EOENT) may disclose the following health care information (check all that apply):

☐ All of my health information maintained by EOENT.

☐ My health information for the following date(s): _____

☐ My health information related to following treatment/condition: _____

☐ Other: _____

Please note: I understand that health information released may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse. *** **(Please initial)** _____ I authorize EOENT to release of this information.

EOENT may disclose this health information to:

Name and/or organization:_____

Address: _____ City & State:_____ Zip Code:_____

Reason(s) for this authorization (check all that apply):

☐ At my request

☐ Other reason: _____

☐ Check here only when EOENT requests this authorization for marketing purposes

This authorization ends:

☐ On (date): _____

☐ When the following event occurs:_____

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2. My Rights

I understand I do not have to sign this authorization in order to receive health care benefits, for example treatment, payment or enrollment.

However, I do have to sign an authorization form:

- To take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did revoke this authorization, it would not affect any actions already taken by EOENT based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from EOENT.
  or
- Write a letter to EOENT.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient: _____ Date: ___/___/_____ Time: _____

OR legally authorized person to sign on behalf of the patient:

Signature legally authorized individual: _____ Date:__/__/____ Time: _____

Relationship (parent, legal guardian, personal representative, etc….) _____

Printed name of person signing above on behalf of the patient:_____