ENT & ALLERGY ASSOCIATES, S.C.

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Wausau, WI 54401
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Authorization for Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

Address: _____

I authorize this use and/or disclosure of my protected health information:

From:

ENT & Allergy Associates
2801 Westhill Dr.
Wausau, WI 54401

To:

Name: _____

Organization: _____

Address: _____

City, State, Zip: _____

Phone, Fax: _____

Information to be disclosed includes:
Please provide specific dates or occurrences that will specifically identify the information you are requesting:

_____

_____

_____

Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subjected to federal health information privacy laws, they may further disclose the protected health information and I may no longer be protected by federal health information privacy laws. I understand I have the right to revoke or review the disclosure/materials at any given time. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If request is made by another legally authorized person, please state relationship/legal authority enabling you to act on behalf of the subject individual:

Relationship: _____

Signature: _____ Date: _____

Processed By: _____ Date: _____