EAR NOSE & THROAT CLINIC

FAIRBANKS HEARING & BALANCE CENTER

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AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED MEDICAL HEALTH INFORMATION

PLEASE CIRCLE ONE: SELF PARENT/LEGAL GUARDIAN

Name of Patient:_____DOB:_____

I, (print name)_____authorize the following person(s) to use and/or disclose my health information as identified below:

Name and relationship to patient:_____

Name and Relationship to patient:_____

Name and relationship to patient:_____

Name and relationship to patient:_____

Name and relationship to patient:_____

By signing below, I authorize the disclosure on all of the following information, unless otherwise specified:

- ☐ Provide Chart Notes
- ☐ Emergency and Urgent Care Records
- ☐ X-Ray Reports
- ☐ Pathology and Laboratory Records
- ☐ Immunotherapy Records
- ☐ Billing Statements and Records
- ☐ Audiometric Studies
- ☐ Phone Correspondence

Other:_____

_____

_____

I understand that I may revoke this authorization at any time by giving written notice to the medical records department. Unless revoked, this authorization will be in effect as of the date of signing.

_____ Date: _____/_____/_____

Signature