Eastern Oklahoma
Ear, Nose & Throat, Inc.

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient's Name: _____

Date of Birth: ____/____/_____ Chart #: _____

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 the 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, i.e. 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.

If I choose to revoke this authorization, there are two options:

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

Once the office discloses health information, the person or organization that receives it may redisclose it; privacy laws may no longer protect it.

Signature of Patient: _____

Date Signed: _____

Time: _____

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

Signature of legally authorized individual: _____

Date Signed: _____

Time: _____

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

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