East Alabama Ear, Nose & Throat, PC

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1965 First Avenue
Opelika, Alabama 36801
(334) 705-0012

HIPAA AUTHORIZATION FORM

Patient Name: ______________________________ **DOB:** ____/____/____

I authorize East Alabama Ear, Nose and Throat, PC to use and disclose the above mentioned patient's, protected health information (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

☐ Appointments ☐ Restrictions ☐ Medications
☐ Released from care ☐ Date of visit ☐ Reason for visits ☐ Diagnosis

Entity or person(s) authorized to receive this information: **FAX NUMBER:** ____________________

☐ School/Daycare/Preschool ☐ Camp ☐ Employer
☐ Personal Representative's Employer ☐ Truant Officer ☐ Parole Officer
☐ Family/Friends ☐ Social Worker

This PHI is being used or disclosed for the following purposes:

☐ Work/School Excuse ☐ To verify restrictions ☐ Verify return to work/school

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

☐ Date ____/____/____ ☐ No longer in school ☐ Employment terminated
☐ Released from care ☐ Child reaches age of majority

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 1965 1st Avenue, Opelika, AL 36801. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

______________________________________ ____________________
Signature of Patient or Personal Representative Date

Fax back to 334-705-0378.