South Lake ENT & Audiology

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request South Lake ENT & Audiology to provide me or the person listed below with access to all protected health information about me that is maintained by South Lake ENT & Audiology. Specifically, I would like to:

- ☐ Inspect my protected health information;
- ☐ Inspect a summary or explanation of my protected health information;
- ☐ Obtain a copy of my protected health information; or
- ☐ Obtain a copy of a summary or explanation of my protected health information.

I would like to:

- ☐ Pick up the copy or summary/explanation I requested;
- ☐ Have South Lake ENT & Audiology mail the copy or summary/explanation to me or to someone else at the address written below; or
- ☐ Receive the copy or summary/explanation on ___ paper or ___ CD or flash drive or __ by e-mail.

Patient name: _____ Date of birth: _____

Name of person to receive copy (if applicable): _____

Recipient's address: _____

Recipient's e-Mail address: _____

Patient's telephone: _____ Patient Number: _____

Dates of treatment: From _____ to _____

(Write *"all"* if you want information for all dates of treatment)

I understand that I **may be charged a fee** for the preparation of a summary or explanation of my protected health information. I also **may be charged a fee** for reproduction costs to obtain a copy of my protected health information or to obtain a copy of the summary or explanation. If I ask to have the information mailed to me, I understand that I **may be charged a fee** for mailing costs. If I ask for an electronic copy of my protected health information, I understand that I **may be charged a fee** for the media (CD, flash drive) on which my copy is stored and provided to me and for the labor costs associated with making the copy. If I ask to have information e-mailed to me or another person, I understand that sending e-mails is not always secure, and I agree that I will not hold South Lake ENT & Audiology responsible if the information e-mailed is intercepted by an unauthorized third party.

[OVER FOR SIGNATURE]

Signature of Patient or Representative

Date

Print Name

Relationship of Representative to Patient (please describe Representative's authority to act on behalf of the Patient): _____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize **South Lake ENT & Audiology** to disclose the following information from the medical records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Patient Number: _____

Covering the period(s) of health care:
From _____ to _____

From _____ to _____

Information to be disclosed:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
OR
Select from the following (check as many as apply):

☐ Discharge Summary
☐ History and Physical Examination
☐ Consultation Reports
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
☐ Mental health care or services
☐ Psychotherapy Notes
☐ Treatment for alcohol and/or drug abuse
☐ Photographs, videotapes, digital or other images

☐ Other (please specify) _____

_____

This information is to be disclosed to the following individual or entity for the purpose of:

_____

_____

Name: _____ Relationship: _____

Address: _____

_____

Telephone: _____
The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of _____.
Initials: _____

b. I understand that I may revoke this authorization at any time by notifying **South Lake ENT & Audiology** in writing, but if I do it won't have any effect on any actions **South Lake ENT & Audiology** took before it received the revocation. Initials: _____

c. I understand that **South Lake ENT & Audiology** cannot make me sign this authorization as a condition to receive treatment from **South Lake ENT & Audiology** except:

(i) when **South Lake ENT & Audiology** provides me with research-related treatment; or

(ii) when **South Lake ENT & Audiology** provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
Initials: _____

South Lake ENT & Audiology its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

_____
Signature of Patient or Representative

_____
Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____

_____

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****