Note: To negotiate from one field to the next, use the tab key on the computer keyboard.

Print Form

Reset Form

Boulder Valley Ear, Nose & Throat Associates, P.C.

Authorization to use or disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name	Date of Birth (mm/dd/yyyy)	Social Security Number

Address (street, city, state, zip)

Telephone# _____

Fax# _____

The following individual or organization is authorized to make the disclosure:

Boulder Valley Ear, Nose, & Throat Associates, P.C.
4745 Arapahoe Avenue #130
Boulder, CO 80303

Ph# (303) 443-2771
Fax# (303) 443-2784

This information may be disclosed to and issued by the following individual or organization:

Boulder Valley Ear, Nose & Throat Associates, P.C.

information release to:

Name:	_____	Phone#	Fax#
Address	_____	_____	_____
city/state/zip	_____	_____	_____

Dates of Service to be copied:
from _____ to _____
all records

Purpose of request:

The following information is to be disclosed: *(Please check on box for each item)*

Yes	No	
☐	☐	physician notes
☐	☐	surgery reports
☐	☐	path reports
☐	☐	hearing tests
☐	☐	complete record
☐	☐	other _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases AIDS or infection with HIV. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for Redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:
(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
(If I do not specify an expiration date, event, or condition, this authorization will expire in 6 months.)

Signature of Patient or Legal Representative _____ Date

If signed by Legal Representative, relationship to patient:

Reason for Transfer: ☐ changed insurance ☐ re-location out of area ☐ other

Dissatisfied with practice - Reason: _____

_____

Print Form