Ear, Nose and Throat Associates of Chester County
80 West Welsh Pool Road, Suite 103
Exton, PA 19341-1224
(610) 363-2532
Fax: (610) 363-0210

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME (printed):_____ DOB:_____
Patient address: Street: _____ City:_____ State:____ Zip Code:_____
Phone # Where We Can Reach You _____
I, _____, hereby authorize ENTACC to release the following Protected Health Information (PHI) regarding treatment dates:
_____
_____

CHECK INFORMATION TO BE RELEASED: (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.)

_____ Radiology Reports _____ Consultations _____ Hearing Tests
_____ Laboratory Reports _____ History and Physical _____ Office Notes
_____ Other: _____

INFORMATION TO BE RELEASED TO:
Individual or Organization:_____
Address:_____
_____

I understand that this information is being requested for the specific purpose of: _____
_____
A copying and mailing charge (and chart review charge, if required) will be based on our costs. The practice must receive payment from the patient or remuneration from a third party in exchange for using, mailing or disclosing the PHI.

I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) by written communication to the "Privacy Officer," ENTACC, 80 West Welsh Pool Road, Suite 103, Exton, PA 19341 under Pennsylvania Law (Act 148). If psychological reports are to be sent, I have been informed of my right, subject to Section 5100-34 of the Mental Health Procedures Act, 1984, to inspect the information to be released, I do not have to sign this authorization in order to receive treatment from ENTACC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I understand that I may inspect and/or copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the Privacy Officer as listed above.

THIS CONSENT SHALL BE IN EFFECT FOR 180 DAYS FROM THE DATE SIGNED UNLESS SPECIFIED OTHERWISE BY THE PATIENT TO EXPIRE ON: ____/____/____ (CANNOT EXCEED 180 DAYS).
MO./DAY/YR.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____ _____
Witness Relationship/Title Date

INSTRUCTIONS:
1. Complete all blanks and sign.
2. Return "Attention Medical Records."

Checking these blanks will allow release of specific information to the above named individual/organization.

• PLEASE ALLOW 1-2 WEEKS FOR PROCESSING •