Ear, Nose, & Throat care for your family

Georgetown ENT
a professional association

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

I specifically authorize ***Scott W. Franklin, MD, Georgetown ENT, Georgetown Better Hearing Center and Georgetown Allergy & Sinus Center*** *(collectively referred to as* ***The GENT Group****)* or his/her designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the 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 state or federal privacy regulations.

Information regarding patient for whom authorization is made:

Full Name: ____

Other Name(s) Used: ______________________________ Date of Birth: __________________________

Address:______________________________ City:________________ State:______ Zip Code:_______

Phone: (_____)__________________________ Email (*Optional*): _______________________________

Information regarding health care provider or health care entity authorized to disclose this information:

Name: **Scott W. Franklin, MD & The GENT Group**

Address: **3201 S. Austin Ave., Suite 370** City: **Georgetown** State: **TX** Zip Code: **78626**

Phone: **(512) 869-0604** Fax: **(512) 868-5936**

Information regarding person or entity who can receive and use this information:

Name: ____

Address:______________________________City:_______________ State:________ Zip Code:_______

Phone: (_____)__________________________ Fax: (_____)__________________________________

Specific information to be disclosed:

□ Medical Record from (insert date) ___________________ to (insert date) ___________________

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: ____

Include: (*Indicate by Initialing*)

________ Drug, Alcohol or Substance Abuse Records

________ Mental Health Records (Except Psychotherapy Notes)

________ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

________ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)

□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other *(Specify)*: ___________________

<u>The individual signing this form agrees and acknowledges as follows</u>:

(i) **<u>Voluntary Authorization</u>:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **<u>Effective Time Period</u>:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: ________ Day: ________ Year: _________.

(iii) **<u>Right to Revoke</u>:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **<u>Special Information</u>:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **<u>Signature Authorization</u>:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: ____ Date:________________

If Legal Representative, relationship to Patient: ____

Witness (optional): ____ Date: ______________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____________________________________ Date: ______________