South Florida ENT Associates, P.A.

Request for Authorization to Release or Obtain Copy of PHI

Patient Name: _____ Date of Birth _____

I, _____, hereby authorize South Florida ENT Associates, P.A. to
(Patient or Legal Representative)

(check those that apply):

__ use the following protected health information, and/or

__ disclose the following protected health information to:

_____

[Name of entity or person to receive information]:

Address: _____

Phone: _____ Fax: _____

1. Specifically describe the information to be used or disclosed

_____

_____

2. This protected health information is being used or disclosed for the following purposes:

_____

_____

Note: South Florida ENT Associates, P.A. may impose a reasonable fee for supplies and labor of copying or for preparing an explanation or summary if requested.

_____ _____
Signature of Patient or Personal Representative | Name of Patient or Personal Representative (please print)

_____ _____
Date | Relationship to patient (or other authority to serve)

_____ _____
Received by (Office/Practice Staff Manager) | Date

If the request is for access to records that are not maintained in our practice (i.e. stored off site) the timeframe may take up to thirty (30) days from the date of this request.

If we are unable to provide the requested access action within the time periods, specified, we may extend the time period by an additional (30) days. If the additional time is required, the Physician or Privacy Officer will furnish you with a written explanation of the reason(s) for the delay and the date we will provide the requested access.