STARK ENT, ALLERGY & SINUS CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

IN ACCORDANCE WITH FEDERAL GOVERNMENT PRIVACY RULES IMPLEMENTED THROUGH HEALTHCARE PORTABILITY ACT OF 1996 (HIPPA), IN ORDER FOR YOUR HEALTHCARE PROVIDER OR STAFF OF THOMAS STARK ENT TO DISCUSS YOUR CONDITION WITH MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS THAT YOU DESIGNATE, WE MUST OBTAIN YOUR AUTHORIZATION PRIOR TO DOING SO. IN THE EVENT OF A CRITICAL EPISODE OR IF YOU ARE UNABLE TO GIVE YOUR AUTHORIZATION DUE TO THE SEVERITY OF YOUR MEDICFAL CONDITION, THE LAW STIPULATES THAT THESE RULES MAY BE WAIVED.

(PRINT) ***PATIENT NAME:*** _____***DATE OF BIRTH:*** _____

_____ ***I DO NOT AUTHORIZE*** THOMAS STARK ENT TO RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE TO ANY INDIVIDUAL EXCEPT AS SET FORTH ABOVE.

_____ ***I DO AUTHORIZE*** THOMAS STARK ENT TO VERBALLY RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE TO THE FOLLOWING INDIVIDUALS:

NAME: _____***RELATIONSHIP TO PATIENT:*** _____

NAME: _____***RELATIONSHIP TO PATIENT:*** _____

NAME: _____***RELATIONSHIP TO PATIENT:*** _____

NAME: _____***RELATIONSHIP TO PATIENT:*** _____

PATIENT SIGNATURE: _____***DATE:*** _____

WITNESS SIGNATURE: _____***DATE:*** _____