Western New York Ear, Nose & Throat, P.C.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PURPOSE: The purpose of this form is to obtain protected health information from another healthcare provider. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those that are described in our "Privacy Policy" notice. The information requested will be used only to aid in provided specific healthcare services to me. It is intended for the exclusive use of the addressee. This authorization will remain in effect for 90 days from the date of the request, unless I specify otherwise.

TO:	**From:**
Western New York Ear, Nose & Throat, P.C. **260 Redtail Drive** **Orchard Park, NY 14127** **Phone: (716) 675-5711** **EMR Fax: (716) 675-3197**	_____ _____ _____

Patient Name: _____ Address: _____

City: _____State: _____ Zip: _____

Date of Birth: _____ Telephone Number: _____

I hereby authorize release of the following protected health information. (Please note, under HIPAA regulations, "all records" is not an acceptable request). Please be as specific as possible by providing dates of service, type of service, name of physician who treated you, etc.

□ Progress Notes: _____

□ Surgical Records: _____

□ Audiometric testing: _____

□ X-rays, CT Scans, Lab Work, ect.: _____

□ Other (please describe): _____

_____
I understand and accept the terms of this authorization by signing below:

_____
Signature of Patient, Parent or Personal Care Representative Date:

Relationship to Patient (if applicable): _____