Ear, Nose & Throat Specialists of Wisconsin, S.C.

Authorization for Release of Patient-Identifiable Health Information

Effective as of: _____ **Medical Record #:** _____

Patient Name: _____ **Patient DOB**: _____

I authorize the use or disclosure of the above-named individual's health information as described below. I understand this authorization is voluntary and that I have the right to refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of service or the ability to obtain treatment except as provided in the "Prohibition of Conditions" section of this form

The following individual or organization is authorized to make the disclosure:

Individual/Organization Name: _____

Address (street, city, state, zip code): _____

_____

The following individual or organization is authorized to receive the disclosure:

Individual/Organization Name: _____Attn: _____Fax: _____

Address (street, city, state, zip code): _____

_____

The person/organization authorized to use/disclose the information will receive compensation for doing so.

YES_____ **NO** ___X_____

Describe the type and amount of information to be used or disclosed as follows:

_____

- ❑ **Health care information related to mental health, alcohol or drug abuse, or a developmental disability**
- ❑ **HIV Test results** According to Wis. Stat. § 252.15, I have the right to request a list of releases made of my HIV test results without my consent.

Purpose of the use or disclosure: *(If the individual requests the authorization, this may read "as requested by the individual")*

_____

Right to Inspect or Copy the Information to be Used or Disclosed

I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact ENT Specialists of Wisconsin's Privacy Officer for such purposes.

Right to Receive a Copy of this Authorization

I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

Re-disclosure of Information by Recipient

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact ENT Specialists of Wisconsin's Privacy Officer at 119 E. Bell St., Neenah WI 54956 (920) 969-1768.

Prohibition of Conditions

ENT Specialists of Wisconsin may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information; provided, however, that:

- If the purpose of this Authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this Authorization, ENT Specialists of Wisconsin reserves the right to deny treatment associated with such research; and
- If the purpose of this Authorization is to disclose health information to another party based on health care this is provided solely to obtain such information, and I refuse to sign this Authorization, ENT Specialists of Wisconsin reserves the right to deny that health care.

Right to Revoke Authorization

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must provide the revocation in writing to ENT Specialists of Wisconsin. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if ENT Specialists of Wisconsin uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

Right to ENT Specialists of Wisconsin Notice of Privacy Practices

I understand that I have a right to request and receive a Notice of Privacy Practices from ENT Specialists of Wisconsin

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship to patient, or representative's authority to act for the patient, if applicable