EAR NOSE & THROAT SPECIALTIES P.C.

Patient Name:_____**Date:**_____

HIPAA Privacy Authorization Form
**Authorization for Use or Disclosure of Protected Health Information

****1. Authorization****
I authorize **ENT SPECIALTIES, PC** to use and disclose the protected health information described below to myself and to the following users:

NAME	RELATIONSHIP	PHONE #
NAME	RELATIONSHIP	PHONE #

****2. Effective Period****
This authorization for release of information covers the period of healthcare from:

a. □ all past, present, and future periods.
OR
b. □ _____ to _____.

****3. Extent of Authorization****

a. □ I authorize the release of my complete health record
OR
b. □ I authorize the release of my complete health record with the exception of the following information:_____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
PATIENT SIGNATURE/RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT**

Appointment of Authorized Representative

(This authorization is to be used only in the event that someone else will be representing you in this appeal.) In the event a claim is denied and needs appealed, you can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.
I hereby authorize **ENT SPECIALTIES, PC** to pursue my appeal on my behalf.

Patient Name: (Please Print)

_____ _____
Signature of Covered Person (or legal representative) **Date:**
(Parent, Guardian, Conservator or Other – Please Specify)

Address of Authorized Representative: 5055 A Street, Suite 300, Lincoln, NE 68510