BEACH CITIES ENTS
EAR NOSE THROAT SURGEONS

AUTHORNIZATION for RELEASE of PROTECTED HEALTH INFORMATION (PHI)

In general, the HIPAA privacy ruled gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home. I wish to be contacted in the following manner (please check all that apply):

Cell Phone Number _____ **Other # _____**

Home Telephone _____ **Name_____**

Work Telephone _____ **Relationship_____**

Written Communication:

O.K. to mail to my home address _____
O.K. to mail to my work/office address _____
O.K. to fax to _____

I hereby consent to the release of Protected Health Information (PHI) to the following individuals. I understand this authorization will be in effect until which time it is revoked. *Write NONE if no one to list.*

Name	***Relationship***
_____	_____
_____	_____
_____	_____

Patient Signature **Date**

Patient Name: _____

Patient Date of Birth: _____

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