FAYETTEVILLE OTOLARYNGOLOGY
Ear, Nose & Throat Surgery • Allergy
Advanced Hearing Services

FAYETTEVILLE OTOLARYNGOLOGY
Head & Neck Surgery, P.A.

1839 Quiet Cove
Fayetteville, NC 28304
(910) 323-1463

Consent Release of Patient's Health Information

As a patient of Fayetteville Otolaryngology, you are entitled under the **Federal HIPPA Act of 2003** passed by Congress to access or release your personal protected health information, as well as to expect proper protection of your health information maintained in a designated record set. In order to process your request for access or release of your information please complete this form and submit it to the medical records department. When received, we will use the information to verify your identity and process your request. Should you have any questions or concerns, you may visit the website www.hippa.org or contact the administrator at (910) 323-1463.

Patient Demographic Information

Patient name _____ Doctor _____ Date of request _____ D.O.B. _____

Last 4 of SS# _____ Reason for release (circle one) hospital - personal - attorney - physician (whom)

Option #1 Release my Personal Health Information to Fayetteville Otolaryngology

I agree to allow the physician below and their staff to disclose my personal health information for continuing my ENT medical care to Fayetteville Otolaryngology. If my medical health record contains any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, sexually transmitted disease, or includes records from other healthcare providers, I agree that I am hereby authorizing the release and use of this information.

Request release from Dr. _____ address _____

Request release to: Fayetteville Otolaryngology Head & Neck Surgery, P.A. - 1839 Quiet Cove, Fayetteville, NC 28304

_____ All my personal health information _____ Only the following information: _____

Option #2 Release my Personal Health Information to myself or another entity Access Method

You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below your wish: If you select "obtain a copy" please indicate your method of delivery. Please note any and all fees you may be charged. I understand that Fayetteville Otolaryngology is given thirty days to process my request for access if my information is maintained on site, sixty days if the information is maintained off-site.

_____ I would like to only view my protected health information. I understand that a staff member will sit down with me for the review process.

_____ I would like a copy of my protected health information. I understand that Fayetteville Otolaryngology may charge me a fee for the copies as set forth in the following schedule:

No charge	1 - 5 page
$ 5.00	6 - 10 pages
$10.00	11 - 15 pages
.50	**any additional pages**

*If there is one specific item in your record that you need please make note: _____

Delivery Method

_____ I will return to Fayetteville Otolaryngology to pick up the copies when ready. Daytime # _____

I understand that I will be charged for my records according to the above fees.

_____ I would like Fayetteville Otolaryngology to send the copies via U.S. mail to the following address:

_____

I understand that I will receive an invoice for all postage fees applicable.

_____ I would like Fayetteville Otolaryngology to send the copies via facsimile to the following physician:

_____ _____

(physician) (fax number)

I understand that my rights are limited to any information in my designated record set as defined in Section 164.501 of the Code of Federal Regulations. I understand I have the right to refuse to sign this authorization, but ENT treatment could be limited. I understand that I may revoke this authorization at any time by notifying Fayetteville Otolaryngology in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken before receiving my revocation. This authorization is in effect from the date signed below and only thereafter until the requested documents have been received. By signing below, I acknowledge and agree to the above conditions, also I warrant that I have authority to sign this document and authorize the use or disclosure of PHI and that there are no restrictions that would prevent me from authorizing the use or disclosure of this PHI.

_____ _____ _____

Signature of patient / parent / legal guardian Relationship to patient Date

***Office Staff Initials _____ ***Processed date _____ ***Already given patient copies _____