north valley
ear, nose & throat
associates, PC

**Peter C. Kaiser, MD**
**Michael T. Gutman, MD**
**Joseph A. Chiara, MD**
board certified
otolaryngology, head and neck surgery

# Authorization to Disclose Protected Health Information

In order to provide for your healthcare, **North Valley E.N.T. Associates, P.C.** maintains record of physical examinations, test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

This authorization gives **North Valley E.N.T. Associates, P.C.** permission to disclose the elements of my protected health information listed below for the purposes of continued medical treatment, unless otherwise stated by the requesting party.

**** I UNDERSTAND THAT THERE WILL BE AN ADMINISTRATIVE FEE OF $30.00 FOR PERSONAL RECEIPT OF ANY COPIES OF MEDICAL RECORDS BEYOND MY FIRST REQUEST. PLEASE INITIAL HERE _____.**

You may email, fax, or drop off your records request at our office (refer to bottom of page).

NAME OF PATIENT: _____ PATIENT'S DATE OF BIRTH OF: _____

North Valley E.N.T. Associates, P.C. may disclose the following health information:

☐ All Records ☐ Radiograph Reports ☐ Lab Reports ☐ Office Visit Notes

☐ Other – Please Specify: _____

Purpose for which the authorization is being requested: _____

The health information requested is to be disclosed VIA (Check One):

☐MAIL ☐FAX ☐PICK-UP ☐EMAIL _____

Recipient _____

Address _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

This authorization will remain valid until _____ or until the following event related to this authorization takes place: _____, after which time it will become invalid.
I understand that I may revoke this authorization in writing at any time, but that this revocation will not affect any prior authorized disclosures that have been taken by **North Valley E.N.T. Associates, P.C**.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient Or Personal Representative | Date | Printed Name & Relationship to Patient (*if not self*) |

**(Office use only):**
Request Completed by _____ on _____. Notes: _____.

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