BONNER GENERAL HEALTH
Ear, Nose & Throat

203

606 North 3rd Ave, Suite

Sandpoint, Idaho 83864
Phone (208)265-1003*Fax (208)265-1013

Authorization for Release of Information

The HIPPA Privacy Law allows Bonner General Ear, Nose and Throat to charge for copies of records. See reverse for details.

PRINT Patient Name_____**Date of Birth**____/_____/

☐ I hereby authorize_____ to release my individual identifiable health information to Bonner General Ear, Nose and Throat

☐ Bonner General Ear, Nose and Throat to release my individual identifiable health information to

Method of receipt/transmission (check one and complete);

☐ Mail (address)
☐ Fax-#
☐ Patient Pick up

Purpose for which information is to be used (circle all that apply)

Treatment Insurance Personal Follow Up Legal Other

Specific description of information (include dates)

☐ Core Chart (up to 10 pages)-Notes from 3 most recent dates of service, most recent test results.
☐ Other

I hereby release the providing person(s)/organizations(s) from all legal liability that might arise from the release of this sensitive information protected by Title 42 of the Code of Federal Regulations
INITIAL:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I consider a copy of this authorization be as valid as the original. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may see and obtain a copy of the information described on this form if I ask for it and that I may get a copy of this form after I sign it. I understand that a fee for copies may be imposed by the person(s)/organization listed above or by its designated business associates.

I understand that this authorization will expire one year form the date of my signature. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying the person(s)/organization(s) above.

Signature of Patient or Patient Representative Date