Midwest Ear Institute, P.C. · 7440 N. Shadeland Ave, #150 · Indianapolis, IN 46250
Phone: (317) 842-4901· Toll Free (800) 818-3277 · Fax: (317) 842-4393

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Name of Patient/Previous Names Birth Date

_____ _____
Street Address City, State, Zip Code

AUTHORIZES: **TO RELEASE HEALTH INFORMATION TO: *****
❒ Midwest Ear Institute, P.C. ❒ Other: ❒ Midwest Ear Institute, P.C. ❒ Other:

_____ _____
Name of Health Care Provider/Plan/Other Name of Health Care Provider/Plan/Other

_____ _____
Street Address Street Address

_____ _____
City, State, Zip Code City, State, Zip Code

INFORMATION TO BE RELEASED:

❒ History, Phys. Exam, Reports ❒ Operative reports ❒ Consultations
❒ Audiograms ❒ ENG, ECoG, ABR, Rotary Chair testing ❒ Imaging Reports
❒ Allergy Records ❒ Laboratory Reports ❒ **Entire Record**
❒ Other (Specify): _____

For the Following **Date(s):** _____

PURPOSE FOR DISCLOSURE: _____

****I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization*.

RIGHTS WITH RESPECT TO THIS AUTHORIZATON:
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION: This authorization is good until ____/____/____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

PATIENT SIGNATURE: _____DATE: _____
(If signed by other than patient, state relationship and authority to do so.)