Mountain Home ENT & Allergy
626 Burnett Drive ◆ Mountain Home ◆ Arkansas ◆ 72653
(870) 424-4200 ◆ (870) 424-4327 fax

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed:

Covering the Periods of Healthcare: From (date) _____ to (date) _____

Information to be Disclosed:

_____

Purpose of Request:

☐Treatment or Consultation ☐Request of patient ☐Billing or claims payment ☐Other:_____

I, the undersigned, authorize and request **Mountain Home ENT & Allergy** to release/obtain medical information:

☐Release to Patient ☐Release to Other (complete below) ☐Obtain From (complete below):

Name:_____
Address:_____
_____
Phone:_____
Fax:_____

Name:_____
Address:_____
_____
Phone:_____
Fax:_____

Time Limit and Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice, in writing, to Lisa McBrayer, Patient Privacy Advocate, Mountain Home ENT & Allergy. Unless revoked, this authorization is effective through ____/____/____, or one year from the date of signature.

Re-Disclosure:

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____

Printed Name of Patient Address D/O/B

_____

Signature of Patient Telephone Date

Authority to Sign if not Patient:_____

Relationship to Patient