



Authorization for Use and Disclosure of Health Information

Part One: PATIENT'S AUTHORIZATION *(All entries in this section must be completed fully)*

I, _____ (name of patient or patient's representative),
hereby authorize the use or disclosure of my individually identifiable health information as
described in this form.

1. Name of health care provider(s) authorized to provide the information:

South Hills ENT Association
2000 Oxford Drive
Suite 201
Bethel Park, PA 15102

2. Name, address and Fax Number, (if applicable), of person or entity authorized to receive the
information:

3. Provide a specific description of the type of information to be used or disclosed (including
dates). Mark only those choices that apply:

Information needed to complete attached form (to be completed and signed by
provider(s)).

Information to confirm my illness from ___/___/___ to ___/___/___.

Information to document my need for reasonable accommodation of my disability
(describe disability and requested accommodation): _____



___ Acquired immunodeficiency syndrome (AIDS)/ Human immunodeficiency virus (HIV) infection. *(indicate how much and what kind of information is to be disclosed)*

___ Behavioral or mental health services. *(indicate how much and what kind of information is to be disclosed)*

___ Treatment for alcohol and/or drug abuse. *(indicate how much and what kind of information is to be disclosed)*

___ Other: _____

4. Describe each purpose for the requested use or disclosure. Mark only those choices that apply:

___ For marketing other than through face-to-face communication or a promotional gift of nominal value *(if marked, the Practice must complete Part Two of this form)*.

___ Purpose is at the request of the patient or patient's representative; the patient initiated authorization and elects not to provide further description of purpose.

___ Other: _____

5. This authorization will expire on *(mark only one option)*:

a. Expiration Date: __/__/____ (DD/MM/YR) or

b. upon the occurrence of the following expiration event:



- 1) _____ End of the research study
- 2) _____ None, this authorization is for creation and maintenance of a research database or repository.
- 3) _____ Other (description required): _____

Part Two: MARKETING (*this section to be completed by the Practice **ONLY** if the Practice has requested the authorization for marketing*)

The Practice will receive financial or in-kind compensation from a third-party in exchange for using or disclosing the health information as described in Part One of this form (*mark yes or no*).

Yes: _____ No: _____

Part Three: NOTIFICATION OF YOUR RIGHTS AS A PATIENT (or patient's representative):

1. You have the right to revoke this authorization prior to the above stated expiration date or event, except to the extent the Practice has already taken action in reliance on this authorization. If the authorization was obtained as a condition of obtaining insurance coverage, the insurer will have a right to contest a claim under the policy. The revocation will not be effective until it has been received by the Privacy Officer. To revoke this authorization, a written revocation must be submitted to our Privacy Officer at:

South Hills ENT Association

2000 Oxford Drive, Suite 201

Bethel Park, PA 15102

2. South Hills ENT Association may not condition your treatment, payment, enrollment, or eligibility for benefits on the signing of this form, unless the health care is solely for the purpose of creating health care information for disclosure to a third party (i.e. a pre-employment physical or research-related care).
3. You may refuse to sign this Authorization.
4. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by the Federal Privacy Standards.



SOUTH HILLS ENT
ASSOCIATION

Sign below indicate that you agree to release South Hills ENT Association, its health care providers, officers, and other personnel from any legal responsibility or liability for disclosure of the above described information to the extent indicated and authorized herein, have read all three pages of this Authorization and agree with its terms.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative: _____

If signed by the patient's representative the relationship to the patient and description of representative's authority to act for the individual MUST be provided: _____

Initial below to indicate you have received a signed copy of this form:

Patient (or patient's representative's) Initials: _____