**TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.**

*Main Office*: 1405 Centerville Road, Suite 5400, Tallahassee, Florida 32308
Office: (850) 877-0101, Fax (850) 877-2750

## *Authorization for Release of Protected Health Information*

As a patient of Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A., you are entitled under federal law to access your personal protected health information. Please return your completed form to our office. We will use the information to verify your identity and process your request. A Photo ID may be requested at any time.

**PATIENT NAME: _____DATE OF BIRTH: _____**

**Send Records From:**
Tallahassee Ear Nose & Throat
1405 Centerville Rd Suite 5400
Tallahassee, FL 32308
850-877-0101 x 209

**Send Records to:**
Name:_____
Address: _____
City/State/Zip: _____
Phone Number: _____
Fax Number: _____

*I request the following and I understand that there may be a charge for these services:*

*(Please check appropriate box)*

[ ] **VIA SECURE ONLINE ACCESS/PORTAL**
[ ] **TO PICK-UP COPY**
[ ] **TO FAX to # _____**
[ ] **MAIL TO ADDRESS ABOVE**
[ ] **VIA SECURE EMAIL:_____**

**Fee for Copies:**
**Secure online access**: No charge
**Personal use**: $1.00 per page up to 25 pages. Additional pages over 25, $.25 each (according to Florida law)
**Continuing care**: No charge at Doctor's request

[ ] **All Records** [ ] **Last office note** [ ] **Audiogram** [ ] **Labs** [ ] **_____**

**I understand that** Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A is allowed 30 days to process my request for access of my information if maintained on-site, 60 days if the information is maintained off-site, and that the deadline may be extended an additional 30 days if notified in writing of the need for an extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

**I understand that** when my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. The use of disclosure of the information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except in the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such words or information.

**I understand that** the information in my health record may include information relating to **sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV), behavior or mental health services and/or treatment for alcohol or drug abuse**. I agree to such release. **INITIAL AND DATE: _____**

**By signing below, I acknowledge and agree to the above conditions.**

_____ _____ _____
Signature of Patient or Patient's Representative Relationship to Patient (if applicable) Date

**INTERNAL USE ONLY**

ID# (*verified at time of form completion*):_____ Verified by: _____

[ ] Fees Due $_____/_____ initials [ ] ID/Signature Verified at pickup by: _____

[ ] Picked up by authorized representative:

Name_____ ID#_____ PPN Verified by: _____