CUMBERLAND VALLEY ENT CONSULTANTS 11110 Medical Campus Rd #126, Hagerstown, MD 21742
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Name: _____
Last First Middle

Address: _____

Phone: _____
Home Work Cell phone

Date of Birth: _____Social Security No._____

I do hereby authorize Cumberland Valley ENT Consultants to release my Protected Health Information, which includes: (***check all that apply***)

□ Lab Results □ X-rays □ Diagnostic Testing Results □ Medical Record

□ Other (*please specify*)_____ to:

_____

_____

_____

This authorization expires one year from the date of signature.

I understand that I may revoke this authorization at any time, except to the extent that Cumberland Valley ENT Consultants have taken action based on this authorization. I understand that such revocation must be in writing.

I understand that the information disclosed by virtue of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

In addition, I understand there will be a fee charged for the reproduction of the medical records.

_____
Signature **Date**

Relationship to patient: Self Parent/Guardian Personal Representative
(circle one)

For office use only

Disposition of copies: □ Mail to patient
□ Mail to above entity
□ Fax to number:_____
□ Patient will pick up copies.

Staff member's initials: _____