M·O·S·A
Michigan Otolaryngology
Surgery Associates

SURGERY OF THE EAR, NOSE AND THROAT

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: _____ DOB: _____/___/_____
Address: _____
City: _____ State: _____ Zip: _____
Phone (___) _____ SSN: _____

I authorize the custodian of record of: _____ to disclose/release the following information.

Check all if applicable:

- ☐ Complete Medical Record ☐ Billing Records
- ☐ Lab/Pathology Records ☐ Summary
- ☐ X-ray/Radiology Records
- ☐ Other (describe specifically) _____

These records are for services provided on the following dates: _____
The purpose(s) for obtaining this information is: _____

Initial if applicable:
_____I specify that this authorization extends to cover release of information related to HIV/AIDS.

_____I specify that this authorization extends to cover release of information related to Psychiatric and/or Drug and Alcohol abuse treatment information.

Please send the records listed above to: _____

This authorization shall expire no later than: ___/___/___ or upon the following event_____ (whichever is sooner) and may not be valid for greater than one year from the date of signature. You have a right to revoke this authorization.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary, and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date:

_____ _____
Printed name of patient/representative Representative's authority to sign for patient
(i.e. parent, guardian, power of attorney for healthcare)