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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Patient Name: _____

Social Security Number: _____

Date of Birth: _____

1. I, _____ authorize E.N.T. Physicians of Kearney, P.C., and its authorized agents and employees to disclose the above named individual's health information as described below.

2. This information may be disclosed to and used by the following individual or organization:
 Name: _____
 Address: _____

 for the limited purpose of _____.

3. I request a copy of _____
 _____ be sent to the above named party.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to E.N.T. Physicians of Kearney, P.C., 615 West 39th Street, Kearney, NE 68845. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
 _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

6. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy regulations. If I have questions about the disclosure of my health information, I can contact the Office Manager at E.N.T. Physicians of Kearney, P.C.

Signature of Patient or Legal Representative _____
Date

If signed by Legal Representative, describe relationship to Patient