E.N.T. PHYSICIANS OF KEARNEY
and Family Hearing Center

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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 _____, 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: E.N.T. PHYSICIANS OF KEARNEY, P.C.
   Address: 615 West 39th Street
   Kearney, NE 68845
   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 to _____ _____. 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