MASSACHUSETTS
EAR, NOSE AND THROAT ASSOCIATES

3 Meetinghouse Road, Chelmsford, MA, 01824 or 280 Main Street, Suite 140, Nashua, NH 03060
Telephone: 978-256-5557 or 603-594-3025 Fax: 978-256-1835

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize **Mass ENT Associates** to use, disclose, or release my protected health information (medical records) to:

Name/Entity: _____

Address: _____ City: _____ State: _____ Zip: _____

Hold for pick up Mail Copies: Fax to: _____

Purpose of Request: (Please Circle) Personal Continuing Care Insurance Legal Transfer

Other: _____

Health and Personal Information to be released:
Please describe the information you want **Mass ENT Associates** to release, please include dates and details:

_____

_____

Permission about Specific Health Information: Only if you CHOOSE to share any of the following information, please write your initials on the line:

_____ I specifically give permission, as required by state law, to share information in my record about **HIV antibody and Antigen testing, and HIV/AIDS diagnosis** or treatment._____ I specifically give permission, as required by state law, to share information in my record about my **Sexually Transmitted Diseases**.
_____ I specifically give permission, as required by state law, to share information in my record about my **Genetic** information.
_____ I specifically give permission to share information in my record about A**lcohol or Drug treatment**. If this information is shared, I understand that a specific notice, required by state law, shall be included prohibiting the re-disclosure of this confidential information.

Signature - *Please sign and date this form:*

_____ _____

Patient's Signature Date

_____ _____

Parent/Legal Recognized Representative Signature Date

This Authorization to share my information is valid until (Date) _____.If I do not list a date, this permission will last for one year from the signed date. I understand that I can revoke this Authorization at any time by providing a written statement to **Mass ENT Associates** EXCEPT to the extent that the action is already done. By my signature I attest that I am legally recognized representative of the above mentioned patient in accordance with the following _____. The information release pursuant to this Authorization may be disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Mass ENT Associates will not condition treatment on payment of the provision of this Authorization.