



EAR, NOSE & THROAT ASSOCIATES OF NORTHERN COLORADO
THE HEARING AND BALANCE CLINIC

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby consent to the release and disclosure of my personal health information (PHI). I would like the information specifically defined in the following form or format, if it is readily producible in this form:

I am Requesting

- All Records The portion of my records concerning: _____

I would like my records:

- From: _____ To: _____

Fax #: _____ Fax #: _____

- Mailed to: home address/other: (charges may apply) _____

_____ Held at the front desk so I can pick them up
Date to be picked up: _____
 USB Thumb drive: (A \$24.00 charge will apply)
CHARGES: \$ _____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within ten (10) business days of Ear, Nose & Throat Associated of Northern Colorado, P.C. having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing, otherwise this release will expire in one year from today's date.

If not signed by the patient, please indicate relationship to the patient

- Parent or legal guardian of the patient (to the extent minor could not have consented to the care)
 Legal guardian or conservator of an incompetent patient:
 Beneficiary or personal representative of deceased patient
 Other: _____

HIPAA requires that a patient representative supply to Ear, Nose & Throat Associates of Northern Colorado legal documentation of their relationship and legal authority to access patient private health information.

Patient Name	Patient DOB	PHONE#
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PATIENT/GUARDIAN SIGNATURE	RELATIONSHIP	DATE

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider. The first paper copy is free, thereafter charges apply, according to Colorado state law. Because Ear, Nose & Throat Associates of Northern Colorado uses an electronic health record (EHR) to maintain your health records electronically, we must provide you a copy of your protected health information that is maintained by the EHR or other systems in electronic format, if you so desire, and in the format you choose if that format is readily producible. Your records may also be accessed using our patient portal. Please ask for a user name and password if you have not already been given one. Our clinic email is not encrypted therefore, medical records may not be securely emailed to individuals. Should you request unsecured email of your PHI, by signing this form, you acknowledge you have read the risks of unsecured email and are agreeing to assume all risk of receiving an unencrypted, unsecured email of your medical records.