Authorization to Use or Disclose Protected Health Information

Eastern Carolina ENT – Head & Neck Surgery, Inc. complies with applicable Federal Civil Rights laws and does not discriminate based on race, color, national origin, age, disability or sex.

Patient Name _____ DOB _____ SSN _____

Address _____

I hereby authorize Eastern Carolina ENT – Head and Neck Surgery, Inc., or _____ to disclose my medical records to the following:

Person/Facility _____

Address or Fax number to which they are to be released. _____

Medical information requested to be released:

- ☐ All Records
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Other _____

Expiration: Unless otherwise stated, this authorization will expire six months from the date this release is signed.

Signature of Patient or Legal Representative _____ Date _____

I understand that any disclosure of information carries with it the potential for re-disclosure, and that the information then may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 252-752-5227.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-752-5227.

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