CAPITAL REGION OTOLARYNGOLOGY
HEAD & NECK GROUP, LLP

Patient Name: _____ Date of Birth: _____

Previous Name: _____ ID#: _____

By signing this form, I hereby authorize Capital Region Otolaryngology to disclose the health information described below to:

_____

(Name of Person or Organization)

Check all that apply:

___ All Health Information

___Health Information relating to the following treatment or condition:

_____

___Health Information for the following date(s):

_____

___Other specific description:

_____

Reason for this Authorization

___At my request

___Other (specify)

_____

___ _____has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

This authorization expires upon

_____

(Date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization, those services may be denied.

6 Executive Park Drive, Ent. C
Albany, NY 12203
(518) 482-9111
(518) 482-6142 (Fax)

2001 5th Avenue
Troy, NY 12180
(518) 274-4111
(518) 274-4110 (Fax)

963 Route 146
Clifton Park, NY 12065
(518) 383-0065
(518) 383-2339 (Fax)

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_____ Date: _____

Patient/Legally Authorized Representative

_____

_____

Printed Name Relationship to Patient

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