

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 o	f Person or Organization)
Michael A. DeVito, M.D. John D. Kopp, M.D. John J. Cevera, M.D. Michelle J. Yoon, M.D.	to, M.D. Check all that apply: op, M.D All Health Information ra, M.D Health Information relating to the following treatment or condition:	
Lyon M. Greenberg, M.D. Mark J. Levenson, M.D.	Health Information for the fo	ollowing date(s):
Jennifer Sulkow, RPA-C, MPAS Audiologists Julie C. Hanson, Au.D., CCC-A Lauren M. Marino, Au.D.,	Reason for this Authoriza At my requestOther (specify)	tion
CCC-A Emily L. Manley, Au.D., CCC-A Kimberly A. Ringie, Au.D., CCC-A	authorization for marketing pur from a third party.	has requested this poses and (will/will not) receive compensation
Susan A. Rest, M.Ed., CCC-A	This authorization expires up	on
Practice Administrator Angela N. Motler	(Date or description of event)	

Pediatric Otolaryngology
Sleep Medicine
Thyroid Surgery
Laryngology
Rhinology
Sinus Disease
Otology-Neurotology
Facial Trauma
Skull Base Surgery
Head & Neck Oncology
Voice
Audiological Evaluations
Vestibular Assessment
Cochlear Implants & BAHA

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.

longer be protected by privacy laws.	
	Date:
Patient/Legally Authorized Representative	
Printed Name Patient	Relationship to

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no

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