Greenbrier Valley ENT, PLLC • Greyrock Professional Park • 152 Dawkins Drive • Lewisburg, WV 24901 • (304) 645-0870 • Fax (304) 645-0970

Authorization Form for Use and Disclosure of Protected Health Information

Protected Health Information requested from:

Physician / Practice: _____

Telephone #: _____

Fax #: _____

Recipient designated to receive Protected Health Information:

Greenbrier Valley E.N.T., PLLC
152 Dawkins Drive
Greyrock Professional Park
Lewisburg, WV 24901

Telephone: 304-645-0870 (available daily from 8:00-12:00, 1:00-4:30)
Fax: 304-645-0970

Direct Line: 304-645-0033 (usually available 7:30-5:30 or later)

Patient Name: _____ Date of Birth: _____

Address: _____ SS#: _____

City, State, Zip: _____ Phone #: _____

Purpose of Request: ☐ Treatment / Consultation ☐ Patient's / Representative's Request ☐ Billing / Claims

Information to be released – covering the periods of health care:

Date from: _____ Date to: _____

Please release the checked information:

☐ Entire Medical Record	☐ Pathology Reports / Results	☐ Operative Reports
☐ History and Physical	☐ Radiologic Images	☐ Consultation Reports
☐ Progress Notes	☐ Radiologic Reports	☐ Admission / Discharge Records
☐ Laboratory Reports / Results	☐ Audiologic Reports	☐ Emergency Department Records
☐ Other:	☐ Allergy Testing Reports / Results	☐ Demographic / Insurance Information

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RELEASE:

I understand that if my medical or billing record contains information in reference to drug and or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B and/or C testing, and/or other sensitive information, I agree to its release:

☐ YES ☐ NO INITIALS ____

I understand that if my medical or billing record contains information in reference to HIV / AIDS (Human ImmunoDeficiency Virus / Acquired ImmunoDeficiency Syndrome) testing and/or treatment, I agree to its release:

☐ YES ☐ NO INITIALS ____

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION:

Except to the extent of action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Greenbrier Valley E.N.T., PLLC, 152 Dawkins Drive, Greyrock Professional Park, Lewisburg, WV 24901. Unless revoked, this authorization will expire in 30 days after receipt, unless an extension is requested.

RE-DISCLOSURES:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by Health Insurance and Portability and Accountability Act of 1996. The facility and its employees, officers, and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE:

I understand that Greenbrier Valley E.N.T., PLLC may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the Protected health Information to be used or disclosed. I authorize the following physician / provider / practice to use and disclose the Protected Health Information specified above:

☐ Greenbrier Valley ENT, PLLC ☐ Christopher White, D.O. ☐ Brent May, PA-C

Signature: _____ Date: _____

AUTHORITY TO SIGN IF NOT PATIENT: _____ DATE: _____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specifiy: _____

Verified by: _____ Date: _____