SACRAMENTO
EAR | NOSE | THROAT

Sacramento Ear, Nose & Throat Surgical & Medical Group, Inc.
1111 Exposition Blvd., Suite 700, Sacramento, CA 95815-4335
Ph: 916-736-3399 | **Fx**: 916-736-3350

Authorization to release Protected Health Information in accordance with HIPAA law.

Patient Name: _____

Current Phone Number: _____

Social Security Number: _____

Date of Birth: _____

1. I, _____, authorize Sacramento Ear, Nose, & Throat and/or S.E.N.T. Hearing Aid Center and their authorized agents to disclose the above named individual's health information as described below**. Please clearly circle what portion(s) of your medical records you are requesting below.**

☐ Office Notes	☐ Procedure Notes	☐ Labs
☐ Imaging	☐ Audiology	☐ ALL
☐ Allergy	☐ Other _____	

2. This information may be disclosed and used by the following individual or organization.

3. I request a copy of _____
Be sent to the above named party via **(circle one):**

☐ **Electronic** ☐ **CD** ☐ **FAX#**_____ ☐ **Mail** ☐ **Pt. Pick Up**

☐ **Email Address:** _____

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to Sacramento Ear, Nose & Throat, Medical Records Department, 1111 Exposition Blvd., Suite 700, Sacramento, CA 95815-4335. I understand that the revocation **will not** apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.
5. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.
6. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy regulations is accordance with 45 CFR 164.524. If I have questions about disclosure of my health information, I can contact Sacramento Ear, Nose & Throat, 1111 Exposition Blvd., Suite 700, Sacramento, CA 95815-4335.

Patient Signature: _____ **Date:** _____

FREE	From our office to another physician's office via electronic messaging
FREE	From our office to the patient via electronic messaging
$15	From our office to the patient via CD
$15 + $0.25/ page	From our office to patient via paper record

Pursuant to 123110 (b) of California Health and Safety Code, healthcare providers are entitled to charge a fee to defray the cost of copying patient records, at the discretion of the practice. Our costs to copy records are as follows.

OFFICE USE

Date Executed _____

Records ☐ ELEC ☐ CD ☐ FAX ☐ MAIL ☐ PT PU

FEE: $15 + $0.25 x _____ pg

TOTAL: **$** _____