Hunterdon Otolaryngology & Allergy Associates
Patient Authorization for Use & Disclosure of
Protected Health Information (PHI)

Patient's Name: ______________________________ D.O.B: _______________

This authorization is given by:

- □ The patient
- □ Parent/Guardian _________________________________

Print Name

The physician/practice may use or disclose the following protected health information:

- □ The entire medical record
- □ Other ____

The purpose of the use/disclosure is:

- □ Continued medical care
- □ Other ____

This authorization is in force until I revoke it in writing. My written revocation must be submitted to:

Hunterdon Otolaryngology & Allergy Associates
Attn: Privacy Officer
6 Sand Hill Road Suite 302
Flemington, NJ 08822

The physicians/practice may disclose to:

- □ Any medical provider/facility
- □ Spouse ____
  Print Name
- □ Children ____
  Print Name(s)
- □ Other _________________________ _____________
  Print Name *Relationship*
  _________________________ _____________
  Print Name *Relationship*

Leaving Messages

□ I give permission for this practice to leave **detailed** messages regarding test results and my medical care. The number that I would like messages left for me is _______________________.

__________ ______________________________ ___________________________________

Date *Patient's Name* *Signature of Patient or Parent/Guardian*

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HOA STAFF ONLY:

- □ Enter into HIPAA fields in NextGen EHR
- □ Form Scanned