MERCY
EAR, NOSE & THROAT CLINIC

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name: _____ Patient's Birth Date: _____

I hereby authorize: _____
(person or institution from whom information is being obtained)

To disclose and/or release to: **MERCY ENT CLINIC**
(name of person or institution needing the information)
901 8th AVE SE , CEDAR RAPIDS, IOWA 52401
PHONE: (319) 398-6900
FAX: (319) 398-6901

Copies or abstracts of medical records pertaining to my evaluation and treatment, as follows (specify dates and types of information to be released – or specify ALL):

ALL RECORD RELATED TO ENT REFERRAL and/or symptom and all audiology reports

I understand the information is to be used for (specify nature and/or reason for release of information:

TRANSFER OF CARE

I understand the information may be released electronically via Epic Care Everywhere Network, and may include information in the following categories, unless I specifically deny the release, as shown below:

I **DO NOT** want information in the following categories to be released (initial blanks below):
Substance Abuse _____ Mental Health _____ HIV-Related Information _____

This authorization will automatically expire in 365 days from the date of signature unless specified differently as:

_____
(specify number of days or months)

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by federal privacy regulations unless otherwise prohibited from redisclosure under other federal and/or state laws or regulations.

Right to revoke or terminate: You have the right to revoke or terminate this authorization by submitting a written request to our Privacy Officer. You may revoke the authorization at any time, in writing, except to extent that your Healthcare Provider or the practice has already processed the request in part or whole prior to receipt of the revocation.

_____ _____
Signature (Relationship if not Patient) Date