CONSENT FOR RELEASE OF MEDICAL RECORDS

ENT Associates of Central PA, LLP
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I hereby authorize Dr. Higgins, Dr. Howells and/or Dr. Caughey to release the records of

____ ___________________
Patient's Name (PRINT: First, MI, Last) Date of Birth

Release records to: ____
Name of Person or Organization

The purpose of the request is:
_____Patient Care _____Insurance ______Workers Compensation
_____Military _____Disability ______Patient Request _____Other

Information to be released (Itemized portions of record and time period):
____
____

I authorize the inclusion of the following types of information which I understand is specifically protected by federal/state statues: (Please initial each one you are authorizing))

_____HIV/AIDS Information _____Alcohol/drug Treatment _____Mental Health Treatment

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance thereon. I will forward any such written request to revoke consent to the Privacy Office. This consent is valid for 3 months or until ___/_____/20____. I understand that authorizing this disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I can inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the receiving party.

_____By my initials, I understand that Drs. Higgins, Howells, Caughey will be reimbursed by the organization to whom the information is being sent for the purpose of copying and providing this information.

_________________________________ ____
Patient Signature Date of Signature

_________________________________ ____
Witness Signature of Responsible Party & Relationship