SOUTHERN UTAH
Ear, Nose and Throat

AUTHORIZATION TO RELEASE INFORMATION

I. I hereby authorize the use or disclosure of my protected health information as described below and understand and acknowledge the following:

- I am not required to sign this authorization and may in fact refuse to sign this authorization.
- The Doctors will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
- If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
- I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Southern Utah Ear, Nose, Throat and Facial Plastics. If I do however revoke this authorization, my revocation will not affect any prior actions taken in reliance on my authorization.
- If I have any questions about this authorization, I may contact Southern Utah Ear, Nose, Throat, and Facial Plastics at (435) 628-3334 or write to: 617 E Riverside Drive, Suite 201, St. George, UT 84790

II. Patient Name: _____ Birth Date: _____

III. The following medical persons or organizations are authorized to make the requested use or disclosure of my protected health information identified above:

Yes	No	
☐	☐	Southern Utah, Ear, Nose, Throat, and Facial Plastics Providers, and full staff
☐	☐	My Primary Care Doctor and other related Physicians and Providers
☐	☐	Other: _____

IV. The following non-medical persons or organizations are authorized to receive my protected health information

Identified bove:	Relationship:
_____	_____
_____	_____
_____	_____

V. This authorization will not expire unless written instructions are sent to Southern Utah, Ear, Nose, Throat, and Facial Plastics

VI. The use or disclosure of the requested information in this authorization may result in a direct or indirect fee payable to Southern Utah Ear, Nose, Throat, and Facial Plastics for the records.

I certify that I have read, signed and received a copy of this authorization.

_____ _____
Patient Name Date

_____ _____
Legal Guardian of patient (if minor) Date

Southern Utah Ear, Nose, Throat, Allergy, and Facial Plastics
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