SOUTHERN UTAH EAR NOSE THROAT OFFICES

NOTICE OF PRIVACY POLICY AND AUTHORZATION TO RELEASE INFORMATION (HIPAA)

I understand that Southern Utah Ear Nose Throat Offices cannot release any of my medical records or information unless I authorize it.

I authorize the following people (persons) to have access to my medical records:

Name: _____
Phone: _____
Relationship: _____

Name: _____
Phone: _____
Relationship: _____

Name: _____
Phone: _____
Relationship: _____

Medical Office or Medical Facility: _____

_____

_____

Patient Name: _____D/O/B: _____

Patient or legal Guardian signature: _____

Date: _____

This agreement will stay into effect each year unless patient asks for it to be terminated.