PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

MEDICAL/ALLERGY/AUDIOLOGY

Patient Name		Date of Birth	
Address/City/ST/Zip		Phone	

MEDICAL RECORDS

RI ENT Physicians, Inc. is authorized to furnish medical information for the above mentioned patient to medical facilities and physicians for all treatment and care. Information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. If necessary, allow them or any physician appointed by them to examine x-rays or other diagnostic records which the facility may have regarding my condition or treatment.

In addition, I hereby specifically consent to the disclosure and release of **"sensitive medical information"** concerning any treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug abuse or dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapists, psychologists, etc. if any.

I release RI ENT Physicians, Inc. from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to RI ENT Physicians, Inc., to the extent that we have already disclosed the information in reliance on this authorization.

SENSITIVE INFORMATION (Place initials by yes or no)	**YES**		**NO**		
Patient Signature (Parent/Guardian if minor)	**Date**				

NOTICE RECEIPT ACKNOWLEDGEMENT

Purpose: This form is used to confirm that an individual has received RI ENT Physicians, Inc. Notice of Privacy and authorization for treatment, evaluation and management of the individual.

1. I acknowledge that I have received RI ENT, Inc. Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices. The content of this notice is inclusive of the Medical Practice, Allergy Practice and Audiology Practice.
2. I request that payment of authorized medical benefits be made on my behalf to RI ENT Physicians, Inc. for any services provided to me by that organization. I understand I will be responsible for payment of services if the insurance company does not cover the service that has been provided.

Signature		**Date**	
Patient Name (Printed)		Insurance ID Number	
Insurance Company		Subsciber DOB	
Insurance Subscriber			

I give my permission for telephone messages to be left on my answering machine regarding upcoming appointments, procedures, test results, billing information, prescriptions and hearing aids/repairs. (Place initials by yes or no)

	YES		NO		

I give my permission for the above information to be disclosed to the following individuals. (Ex: Spouse, family members, etc.)

	YES		NO		

Please list name, relationship and phone number below:

Name		Relationship		Phone	
Name		Relationship		Phone	
Name		Relationship			