HEAD & NECK
Surgical Group
425 West 59th Street, 10th Floor
New York, NY 10019
Telephone 212-262-4444
Fax 212-523-6364
www.entsurg.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: ______________________________ SS#: ______________

I authorize the use and disclosure of individually identifiable health information relating to me, called "protected health information", as described below:

(Examples: any and all medical information, medical visits, surgery, pathology reports, slides, imaging reports)

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This information may be released to:

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FAX # ____

✍✍ Mail ✍✍ Fax ✍✍ Fedex ($15 fee)

This authorization request is for one time use only. Each new request will require a new release. A copy of this form will be provided along with the information sent.

______________	______________________________	______________________
Date	Signature of Patient or Legally Responsible Person	Relationship to patient