Advantage ENT & Audiology
Office 303-431-8881
Fax 303-456-8924

AUTHORIZATION FOR RELEASE OF INFORMATION

Michael Tralla, MD Guardian of Records

This form enables us to release your medical information in accordance with Federal Privacy Regulations for purposes *other than treatment, billing and/or collections.*

I hereby authorize the use or disclosure of my protected health information (PHI) as described below. I understand that this authorization is voluntary.

Patient Name:_____ **Date of Birth:**_____

Persons/organizations receiving the information:

_____
_____
_____

Information to be released:

_____
_____

Purpose of the use or disclosure:

_____

- I understand this information may contain records about alcohol/drug use, psychological disorders and HIV/AIDS status. Inintials:_____
- I understand that this authorization will expire in one (1) year. Initials:_____
- I understand that this authorization will be used for the purposes stated above. Additional releases will require a separate authorization form. Initials:_____
- I understand that I may revoke this authorization at any time by notifying Advantage ENT in writing. Initials:_____

_____ _____
Signature of Patient or Guardian Date