**AUTHORIZATION FOR RELEASE OF INFORMATION**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person/Organization releasing records:**

**Advantage ENT LLP**

**7850 Vance Dr #225 Arvada Co 80003**

**Phone: 303-431-8881 Fax: 1-855-324-5322**

**Persons/organizations receiving the information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone and Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Purpose of the use or disclosure:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand this information may contain records about alcohol/drug use, psychological disorders and HIV/AIDS status. **Initials:** \_\_\_\_\_\_\_
* 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: