



**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

1. **Authorization.** I hereby authorize and request:

(Name of provider or practice)
to release all records of my medical/surgical care currently in your possession to:

**Lakeside Ear, Nose, Throat & Allergy, LLC
4 Coulter Road
Clifton Springs, New York 14432**

2. **Purpose.** This Authorization is granted for the following purpose(s):
the continuation of my medical/surgical care.

3. **Expiration Date/Event.** This Authorization is valid until the following event:
the requested records are delivered to Lakeside Ear, Nose, Throat & Allergy, LLC.

4. **Limitations.** In addition to the above, the following is/are other criteria or limitations
that I make regarding this Authorization:

There are to be no limitations whatsoever.

5. **Voluntary Act.** I expressly acknowledge that this Authorization is voluntary.

6. **Pre-conditions.** I understand that Lakeside Ear, Nose, Throat & Allergy, LLC may
not condition my treatment on my signing this Authorization.

7. **Revocation.** I understand that this Authorization may be revoked by me at any time,
provided that I submit a signed revocation form to the Practice's Privacy Officer. However, any
revocation shall not apply to the records that have already been received by Lakeside Ear, Nose,
Throat & Allergy, LLC.

8. **Re-disclosure.** I understand that my records may be forwarded to any individual or
entity authorized in accordance with the HIPAA Privacy Rules and the policies and procedures
established by Lakeside Ear, Nose, Throat & Allergy, LLC.

Name of Individual (printed)

Signature of Individual

Signature of Personal Representative

Relationship
(e.g., Attorney-In-Fact, Guardian,
Parent if a minor)

Date Signed ____/____/____

Witness: _____