

**LAKE GROVE ENT, P.C.**

MAUREEN MULCAHY, MD • ROBERT FURMAN, MD • MICHELLE VESSELY, MD • CAROLINE YANG, MD  
ERIKA SCHESSLER-HUBERTY, MD • KIMBERLY LAVOIE AU. D, CCC-A • NANCY HENSON, AU. D, CCC-A

## AUTHORIZATION To Use/Disclose Protected Health Information

**AUTHORIZATION** I authorize: \_\_\_\_\_ to use and disclose a copy of the  
(name of person/entity disclosing information)

specific health information below regarding: \_\_\_\_\_  
(name of individual)

consisting of: \_\_\_\_\_  
(describe information to be used/disclosed)

to: \_\_\_\_\_  
(name and address of recipient or recipients)

for the purpose of: \_\_\_\_\_  
(describe each purpose of disclosure)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the applicable space next to the type of information.

- HIV/AIDS information  
 Mental health information  
 Genetic testing information  
 Alcohol/chemical dependency diagnosis, treatment, or referral information  
 Sexually transmitted disease information

**I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal law restricts re-disclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to re-disclosure.**

**PROVIDER INFORMATION** You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to \_\_\_\_\_ (contact person) at \_\_\_\_\_ (address of person/entity disclosing information) and state that you are revoking this authorization.

**SIGNATURE** I have read this authorization and understand it.

Unless revoked, this authorization expires: \_\_\_\_\_  
(insert either applicable date or event)

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(individual or person representative)

Description of personal representative's authority: \_\_\_\_\_