PearceMD
EAR NOSE THROAT • BALANCE & ALLERGY

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I, _____, hereby request and authorize _____ , including its employees and agents, to release and provide _____

_____

_____, except as specifically excluded below, to the following entity/person: **PearceMD, P.A./Dr. Elizabeth Pearce ,** and its employees, agents or representatives via facsimile **207-514-8213** or other prompt, secure transmittal.

This authorization also permits verbally disclosing and discussing the health care information.

Restrictions or Information that may NOT be disclosed: _____.

The purpose of this release is: Continuity of care.

I understand that my health care record contains information relating to my diagnosis and treatment. I authorize the release of all such information listed above, except those items I have specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information.

The authorization is valid for a period of 1 year from the date of signing. I further understand that I may revoke this authorization by written notice at any time during this period except where the disclosing party has already acted upon a request for the release of my medical record. A revocation may result in the denial of dental or other health insurance benefits.

If I have been diagnosed or treated for any of the following, I understand that my specific consent is needed to disclose any related information.

1. I **(□ DO/ □ DO NOT)** authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific written consent.

2. A. I **(□ DO/ □ DO NOT)** authorize disclosure of information which refers to treatment or diagnosis of mental health. Such information may not be re-disclosed by the recipient without my specific written consent.
   B. I **(□ DO/ □ DO NOT)** want to review such information before it is released. I understand that review must be supervised.

3. I **(□ DO/ □ DO NOT)** authorize disclosure of information which refers to HIV test results, infection status, or treatment information. Such information may not be re-disclosed by the recipient without my specific written consent.

I understand that I am entitled to a copy of this authorization. A photocopy of this authorization shall be considered as effective and valid as the original.

X_____ _____ _____

Patient Name: _____ Date of Birth Date of Signing

Signature of Parent or Guardian, if Patient is a Minor (or Under Guardianship): _____
Date: _____