ONSLOW
EAR NOSE & THROAT
affiliated with Onslow Memorial Hospital

Authorization to Release Healthcare Information

Patient's Name:	Date of Birth:
Previous (Maiden) Name:	Social Security #:

I authorize and request _____
to release healthcare information to:

Onslow Ear Nose & Throat
55 Office Park Drive
Jacksonville, NC 28546
Phone: 910-219-337 Fax: 910-577-4983

This authorization and request applies to:

□ Healthcare information related to the following treatment, condition, or dates:
_____
□ All healthcare information.
□ Other: _____

This authorization will expire: (Choose One)

□ Two years after death of patient
□ Upon written revocation
□ Future date: _____

By signing below, I understand:

- I authorize the use and/or disclosure of my protected health information as described in the document.
- I may revoke this authorization at any time by providing written notice of my revocation. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before notice of revocation of authorization was received.
- I may refuse to sign this authorization and the request will be considered null and void.

Patient Signature: _____ Date: _____