Authorization for Release of Information for Purposes Requested by Physician's Office From Another Covered Entity

ATTN:_____

Name of Covered Entity

Patient Name: _____ **D.O.B**.: _____

Social Security # _____

I authorize you to disclose the following protected health information.

(Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____
_____
_____

TO: **SOUTH FLORIDA ENT ASSOCIATES, P.A. – CARE CENTER ____**
PHYSICIAN NAME: _____

_____

_____

_____

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of South Florida ENT Associates, P.A. in the following manner:

(Describe how protected health information will be used to carry out treatment, payment and/or health care operations purposes).

_____
_____
_____

_____ _____
Signature of Patient or Personal Representative Print Name of Patient or Representative

_____ _____
Date Relationship to patient

4/03