# NJ REGIONAL EAR, NOSE & THROAT CENTER, LLC

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Teri Nelson, PA-C

## Authorization for Release of Information to Family Members/Friends

Patient Name_____ Date of Birth_____

Many of our patients allow family members/friends such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members/friends, you must sign this form. By signing this form, this information will be released to the family members/friends indicated below.

I authorize NJ Regional Ear, Nose & Throat Center, LLC to release my medical and or billing information to the following individual(s):

1._____Relation to Patient:_____

2._____Relation to Patient:_____

3._____Relation to Patient:_____

**Patient Information**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient(s) is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing at any time. ***It is the patient's responsibility to notify the office if any of the above recipients' need to be updated/removed.***

Signature:_____Date:_____