SIERRA NEVADA
EAR • NOSE • THROAT

REQUEST FOR PROTECTED HEALTH INFORMATION (PHI)

I, _____ request to review/receive a copy of my medical records from Sierra Nevada Ear, Nose & Throat Associates.

Patient Name: _____ **Patient DOB:** _____

Please Indicate The Records To Be Released:

_____DISCHARGE SUMMARY _____HISTORY & PHYSICAL _____X-RAY & IMAGING

_____CONSULTATION NOTES _____PROGRESS NOTES _____LABS

_____AUDIOLOGY _____ALLERGY TESTING/SHOT RECORD

_____OTHER, PLEASE BE SPECIFIC: _____

Please Indicate Your Preferred Method For Receiving A Copy Of Your PHI:

_____Fax **Fax Number: _____**

Attention: _____

_____Mail **Addressed To: _____**

Street Address: _____

City: _____, State_____, ZIP_____

_____Pickup **Contact Phone: _____**
***You will be contacted when the information is available.**

Please be advised that you will need to make an appointment if you wish to discuss your chart with the doctor. If you are making this request via fax/mail, the signature on file must match the signature on this form. If the signatures do not match we will be unable to release the records and may request a new signed authorization.

I understand that I have a right to receive a copy of this authorization:
COPY REQUESTED AND RECEIVED _____NO _____YES INITIAL: _____

I release the person/agency, disclosing this information from any liability arising from the release of this PHI.

SIGNATURE: _____ DATE: _____

If signed by someone other than the patient, state your legal relationship to the patient: _____

EXPIRATION DATE: THIS AUTHORIZATION IS VALID FOR 30 DAYS FROM SIGNATURE DATE AND ONLY FOR THE RECORDS SPECIFIED ABOVE.