Medical Records Release
PHI Use and Disclosure Authorization
Berkshire ENT & Audiological Associates, P.C

I authorize Berkshire ENT & Audiological Associates, P.C. to use and disclose of the following protected health information: (indicate what records are to be released)

_____

_____

Purpose of the Disclosure**:** _____

Name of Entity or Person(s) to Receive Information:

_____

_____

This authorization is effective through (check one):

☐ _____/_____/_____ or

☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to ***510 North Street, Pittsfield, MA 01201***. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

_____

Name of patient or Personal Representative (Type/Print)

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority