



Brennan T. Dodson, MD

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Legal Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

I authorize: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Fax: _____

To disclose/release the Protected Health Information (PHI) of the patient listed above to:

Person/Organization: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Fax: _____

Purpose: Continuation of Care Personal Insurance Litigation Other: _____

Dates of Treatment: _____ Date Needed: _____

Pertinent PHI Information: Entire record Specific Item: _____

ACKNOWLEDGEMENT: I request and authorize the above-named doctor or health care provider to release the information specified above to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding drug and alcohol abuse, communicable/infectious diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and psychological or psychiatric conditions, if any. I understand that if the receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy regulations and may be redisclosed.

EXPIRATION: Without my express revocation, this authorization will automatically expire one year from the date hereof, unless otherwise specified: _____

REVOCAION: I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must submit a letter to the Director of Health Information Management.

OTHER CONDITIONS: A copy of this authorization with my signature may be used with the same effectiveness as an original. I understand that:

- If I do not sign this authorization, Bridger Ear, Nose, and Throat will still provide treatment and seek payment for services provided.
- Fees/charges will comply with all laws and regulations applicable to release of information.

I authorize: _____ to pick up my Protected Health Information.

Signature of Patient/Patient Representative: _____ Date _____