KINSTON HEAD & NECK PHYSICIANS & SURGEONS, P.A.

ROBERT H. HOSEA, M.D., F.A.C.S.
CHARLES B. BEASLEY, M.D., F.A.C.S.
BARBARA L. GOHEEN, M.D.

701 DOCTORS DRIVE STE K
KINSTON, N.C. 28501
PHONE: (252) 523-0687
FAX: (252) 523-0255

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME:_____DOB_____

I consent to and authorize my records to be sent to:

_____

_____

_____

Please enclose the following:

- ❑ Medical Information including physician notes/summaries, diagnostic results, pathology reports, x-ray reports, and lab reports for the periods from _____to_____
- ❑ Other:_____

_____

The following must be initialed to be included in this request for use or disclosure:

	Patient's Initial
❑ HIV/AIDS related information	_____
❑ Mental health information	_____
❑ Drug & Alcohol treatment information	_____
❑ Genetic testing information	_____

I understand that, if the person or organization receiving this information is not a health care provider, health care organization, or health plan covered by federal privacy regulations, then this information may be redisclosed and no longer be protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken upon this authorization.

_____ _____
Patient's Signature Date

_____/_____ _____
Authorized Agent (if applicable) Relationship Phone Number

_____
Address

_____
City State Zip Code