ent EAR, NOSE & THROAT ASSOCIATES, P.C.

Michael Zoller, M.D., FACS
Fred L. Daniel, M.D., FACS
Stephen P. Rashleigh, M.D., FACS
William H. Moretz, III, M.D.
Brad Rawlings, MD.
Jennifer R. Miles. MD
Michelle Yamada, PA
Kristen Thomas, PA

Otolaryngology / Head and Neck Surgery
5201 Frederick Street
Savannah, GA 31405
(912) 351-3030

www.entsavannah.com

Susan Timna, AuD.
Cori Palmer, AuD
Casey Allen, AuD
Sara King, AuD
Katy Laws, AuD

Pts Name: _____

Pts DOB: _____

Appointment of Representative Authorization

I, _____, give ***ENT ASSOCIATES of SAVANNAH AND SAVANNAH PARTNERS (ENT SURGICAL CENTER)*** permission to Appeal any Claims on my behalf for all services rendered. This Authorization also includes permission to send any records requested by My Insurance Company.

_____
Patient or Guardian Printed Name

_____
Signature of Patient or Guardian

_____
Date

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I, _____, hereby authorize ENT Associates of Savannah, PC to:

___ Use the following Protected Health Information (PHI), and/or
___ Disclose the following Protected Heath Information (PHI):

Family/Friend: _____

Appt. Information Billing Information Medical Records Demographic Info All

Providers: _____

Appt. Information Billing Information Medical Records Demographic Info All

This protected Health Information is being used or disclosed for the following purpose(s):

_____

I direct and hereby authorize ENT Associates of Savannah PC to deliver the PHI specified in the Authorization to the party or parties specified in the following ways, if available:

- Hardcopy Format, such as Paper or Fax
- Electronic Format, such as CD-ROM or Flash Drive
- Email
- No Format Preference

I understand that electronic media and delivery methods such as email pose certain risks to the privacy and security of my PHI that may be beyond the control of ENT Associates of Savannah, PC. I agree to assume such risks personally, and to hold ENT Associates of Savannah, PC harmless in the event my PHI is breached or compromised because of my directing and authorizing ENT Associates of Savannah, PC to transmit or deliver such information electronically.

- I hereby acknowledge that ENT Associates of Savanah, PC will share my medical information, as permitted under Federal Law (HIPPA) and Georgia State Law, with my Healthcare Providers through a health information exchange
- We may make your medical information available electronically through State, Regional or National information exchange services which may help make your medical information available to other healthcare providers who may need access to it to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

Medical Records Authorization
I authorize this provider to obtain or release any of my medical records which may be needed to provide medical care services to me.

Patient Signature: _____ Date: _____

This Authorization shall be in force and effect until _____ at which time this Authorization to use or disclose this PHI Expires.

___ I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Practice Administrator at 5201 Frederick St, Savannah, GA 31405.

___ I understand that a revocation is not effective to the extent ENT Associates of Savannah, PC has relied on this authorization for the use or disclosure of the PHI.

___ I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or State Law.

ENT Associates of Savannah, PC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide Authorization for the requested use or disclose

I understand I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under Federal Law (or State Law to the extent the State Law provides greater access rights).
- Have an electronic copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to Sign the Authorization

The use or disclosure requested under this Authorization will result in direct or indirect renumeration to the ENT Associates of Savannah, PC from a third party (if applicable).

Patient Name: _____ **DOB**: _____

Signature of Patient/Representative: _____ **Date:** _____

Description of Representative's Authority: _____

** FOR OFFICE USE ONLY **

Received by:			
Date Received:		Time Received:	
Action Taken:			
PHI Disclosed to:			
Disclosure Media	__ Hardcopy __ Memory Stick __ CD-ROM __ Email __ Other (describe)		
Discloser Signature:			