

HIPAA Release Authorization

I acknowledge that as part of my medical care, this practice creates and maintains health records that include my medical history, symptoms, examination results, diagnostic findings, treatments, and future care plans. I understand that these records are maintained for the following purposes:

- Coordinating and planning my care and treatment
- Supporting communication among the healthcare professionals involved in my care
- Providing information needed for accurate billing of my medical services
- Confirming to third parties that services billed were actually provided
- Assisting with quality review and evaluation of healthcare provider performance

The Notice of Privacy Practices is posted on the Greater Philadelphia Ear Specialists website and is also available in the main lobby for review. I understand that if a copy of the Notice is requested, it is available and may be obtained at the front desk.

I acknowledge that Greater Philadelphia Ear Specialists, P.C. has made its Notice of Privacy Practices available to me for review, which explains in detail how my health information may be used or disclosed. I also understand that this practice does not use health information for directory purposes.

I understand that I have the following rights:

- To review the Notice of Privacy Practices before signing this authorization
- To request limitations on how my health information is used or disclosed for treatment, payment, or healthcare operations (although Greater Philadelphia Ear Specialists, P.C. is not obligated to accept such limitations)
- To revoke this authorization in writing at any time, except where Greater Philadelphia Ear Specialists, P.C. has already acted in reliance on it

I also understand that Greater Philadelphia Ear Specialists, P.C. reserves the right to amend their Notice of Privacy Practices. If this Notice is changed, a revised copy may be obtained by contacting the office.

This Agreement will be signed in office at time of appointment