Dr. J. Ben Hengy & Dr. Andrew Mendians

Western Michigan ENT
Authorization for Disclosure of Information

Patient Name: _____

Patient Date of Birth: _____

I hereby authorize the use and disclosure of Protected Health Information relating to me as specified below:

Purpose of Disclosure (Specific Description of Information to be Used or Disclosed)

_____

_____

_____

Person (s) receiving my authorized information includes:

_____

_____

_____

I understand that I may revoke this authorization at any time by notifying Western Michigan ENT in writing.

This authorization expires on: _____

Print Name: _____

Signature: _____

Revised 9-26-13 rv

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