Barry S. Tatar, M.D.

Board Certified Otolaryngology
specializing in the medical & surgical treatment of the ear, nose, throat & sinuses

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AUTHORIZATION FOR USE and DISCLOSURE OF INFORMATION

I am a patient of Barry S. Tatar, M.D., LLC, and hereby authorize Barry S. Tatar, M.D., LLC to use, obtain, review and disclose my individually identifiable health information for the purpose stated herein. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Name of Patient of Barry S. Tatar, M.D., LLC:

DOB: ___/___/___

Party to whom information will be disclosed:
☐ Self
☐ Other: _____

Party authorized to make the use or disclosure:
Barry S. Tatar, M.D., LLC

Medical Records of Patient Information to be released:
☐ Entire Record ☐ Description of information to be released: _____

The patient or the patient's legal representative must read and initial the following statements:

a. I understand that the patient's health care and the payment for his/her health care will not be affected if this form is not signed. Initials: _____
b. I understand that this release form is valid for 1 year from today's date. Unless patient prefers that release expires sooner ___/___/___. (DD/MM/YR) Initials: _____
c. I understand that I may revoke this authorization at any time by notifying Barry S. Tatar, M.D., LLC in writing, but if I do it will not affect any actions taken before Barry S. Tatar, M.D., LLC received the revocation. Initials: _____
d. I understand that the information may be redisclosed by Barry S. Tatar, M.D., LLC. Initials: _____

_____ _____
Signature of patient or patient's legal representative Date
(*Form MUST be completed before signing.*)

Print name of patient's legal representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please review the Notice of Privacy Practices concerning your rights.