AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name: ______________________________________ Date of Birth:_________________________

I authorize ENT Specialty Partners to release the above-named individual's health information to:

Name: ____

Address:____

Email: ____ Fax: ____________________________________

For the purpose of: ____

Please release the following visit dates:

☐ Entire Record ☐ All Dates ☐ Date of Service ________________

Please release the following documents:

☐ Physician Notes ☐ Radiology Reports ☐ Radiology Imaging
☐ Laboratory Results ☐ Billing & Payment Records ☐ Other ___________________

Please release in the format below:

☐ Fax Number:_________________ ☐ Mail ☐ My portal (pdf format)
☐ Email Address:_______________ ☐ Hard Copy ☐ Other ____________

By signing this release, I understand:

- that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

  ☐**Yes**, I consent to the release of this information ☐**No**, I do not consent to the release of this information

- that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request.
- that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____________________________________ _________________________ ____________________

Signature of Patient or Legal Representative *Relationship to Patient* *Date*

OFFICE USE: *State law requires that records are to be released within 15 days from the date of a valid request signed by the patient or legal guardian. PLEASE FORWARD COMPLETED FORMS TO Records Department for review/release.*