TEXAN ENT Specialists

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____ **Date of Birth:** _____

Patient Address: _____ **Patient Phone Number:** _____

I authorize ***the release of or request access to*** the medical record information below.

PURPOSE OF REQUEST: PLEASE SELECT *ONE*

Continuing Medical Care	Military	Personal Use	School	Insurance
Legal Purposes	Social Security/Disability	Other: _____		

DATE (s) OF TREATMENT: _____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Radiology Reports	Other: _____
Operative Reports	Radiology Images	
Lab/Pathology Reports	Progress Notes	

METHOD OF DELIVERY:

Pick Up (You will be notified via a telephone call when records are ready for pick up)

Mail or fax to:

_____May release the above information to:
(Facility/Name)

_____
(Facility/Name)

_____
Address (Street, State, Zip Code) Phone & Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records in accordance to Texas Administrative code RULE §165.2 Medical Record Release and Charges law. This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient