Southern E.N.T. Associates, Inc.

Prefix: Mr. /Mrs. Other: _____ Patient: _____
Last First Middle

Suffix: Jr. /Sr. / Other: _____ Date of Birth: _____ Social Security Number: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ EXT: _____

I hereby request and authorize the release of the following medical records on myself (or minor child):

☐STAT REQUEST

☐To: Southern E.N.T. Associates, Inc.
604 North Acadia Road, Suite 101
Thibodaux, LA 70301 ATTN: _____
Phone: 985-446-5079 Fax: 1-877-795-9281

☐ From: Southern E.N.T. Associates, Inc.
604 North Acadia Road, Suite 101
Thibodaux, LA 70301
Phone: 985-446-5079

Circle One: EMAIL MAIL FAX PICK UP (Office Location) ☐Thibodaux (Main) ☐Raceland ☐Gray ☐Morgan City ☐New Iberia ☐Youngsville ☐Opelousas

Name: _____ Phone Number: _____ Fax: _____

Mailing Address: _____ Email: _____

My authorization extends to the data elements/documents listed below: ☐ Dates of Service _____ to _____

☐ All Records ☐ All Itemized Billing ☐ H & P, Progress Notes
☐ Allergy/ Laboratory Test Reports ☐ Radiology Report ☐ Imaging Disc/s (*Mail)* ☐ Pathology Report
☐ Audiology Reports ☐ Other (*Please Specify*): _____ ☐ Operative Report

I ☐ consent ☐ do not consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information: _____
_____.

This Consent is subject to written revocation by the undersigned at any time and the practice is required to honor and abide by that written request, except to the extent that actions relying on your authorization have already occurred.

This authorization is given freely with the understanding that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
- I have the right to receive a copy of this authorization.
- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- A photocopy of fax of this authorization as valid as the original. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period form the date it is signed or noted below.
- The revocation must be in writing. A revocation form is available from the receptionist.

Southern E.N.T. Associates, Inc., its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the information to the extent indicated and authorized herein. By signing below, I agree to all above and agree to abide by all policies of Southern E.N.T. Associates, Inc. I agree that I have read the above or have had it read to me and I authorize the disclosure of the PHI as stated.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Note: Authorized representative must submit copies of legal documents supporting his/her authority to act on the patient's behalf.

Witness Signature: _____ Date: _____

Witness Printed Name: _____

Recipient of Medical Records: This information has been disclosed to your from records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosing it without specific written consent of the patient or otherwise as permitted y state/federal laws. A general authorization for the release of such information is not sufficient for this purpose. Fess will be charged for the unauthorized release of information in accordance with state/federal laws.