Center for Pediatric ENT-Head and Neck Surgery
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Center for Advanced Hearing Care
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REQUEST TO RELEASE MEDICAL RECORDS / AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: ______________________________

DATE OF BIRTH: __________________ PHONE: ______________________________

ADDRESS: ______________________________

CITY: ____________________ STATE: ______________ ZIP: ________________

1. I authorize the use or disclosure of the above-named individual's health information as described below.
2. Otolaryngology Consultants, PA is authorized to **RELEASE** the patient's records.
3. Please send: ☐ **COMPLETE HEALTH RECORD** ☐ **AUDIO REPORT ONLY– Date of Exam: ________**
   ☐ **CT SCAN REPORT ONLY – Date of Scan: ________**
   IF NO EXCEPTION IS CHECKED BELOW A COMPLETE HEALTH RECRORD IS REQUESTED
   Do Not Send: ☐ sexually transmitted disease information; ☐ AIDS or HIV information; ☐ behavioral or mental health services information; ☐ treatment for alcohol and drug use information
4. This information may be released, sent to, and used by the following Physician or Person:

   Name: ______________________________

   Address: ______________________________

   City: ____________________ State: ____________________ Zip: ____________________

   Phone: ______________________________ Fax: ______________________________

5. I understand 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. Unless otherwise revoked, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. 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 laws.
7. I release and hold harmless the Doctors and employees of Otolaryngology Consultant's, PA for all liability including for negligence that may arise from complying with this authorization.
8. I understand that the medical record maintained by Otolaryngology Consultants, PA might contain medical and administrative information from other healthcare providers.
9. I understand that 2011 Florida Statute 456.057 and rule 64B8-10.003, Florida Administrative Code authorize a charge for duplication costs of my medical records of $1.00 per page for the first 25 pages, and $0.25 for all subsequent pages. The records are forwarded after receipt and processing of the fee.

The purpose of this disclosure is for: (CHECK ONE BOX)
☐ **Continuation of Care (must provide a Physicians name in Section 4 above)**
☐ **Personal Records**
☐ **Other (please specify) ______________________________**

I have the legal right to request this disclosure of protected health information.

______________________________ ______________________________ ________________
Print Name and Relationship to Patient **Signature** **Date**

FOR OFFICE USE ONLY

Approved by: __________ Number of pages: __________ Fee: $__________ Date Fee Received: ______________

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