ENT SPECIALISTS
Otolaryngology Consultants, PA

Center for Pediatric ENT-Head and Neck Surgery
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Center for Advanced Sinus And Nasal Care
ALFREDO ARCHILLA, MD
Center for Advanced Hearing Care
MARCI CORNISH, MA, CCC-A • JAMI LEVENTHAL, MA, CCC-A

REQUEST TO RELEASE MEDICAL RECORDS / AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FOR PEDIATRIC USE ONLY

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 Consultants, 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, _____, as a parent or legal guardian of _____ 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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