Authorization for Release of Medical Information to Texas ENT

Patient Name: _____ Date of Birth: _____
Address: _____
_____

Telephone Number: _____

The undersigned hereby waives right to the privilege of confidentiality and authorizes

_____
Name of Physician/Facility Providing Information Street Address City State Phone Number

to "disclose," that is, release and provide a copy, summary, or narrative of your protected health information (otherwise known as your medical records) to:

_____ _____ _____
Texas E.N.T. Specialists Physician Phone Number Fax Number

Street Address City State Zip Code

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial: _____ Date: _____

The disclosures made under this authorization are subject to limitations indicated below:

_____ The complete record.

_____ Records of care from _____ to _____ only.

_____ Records of care concerning the following conditions: _____
_____

The reasons or purposes for this disclosure of information are as follows: _____
_____
_____.

Your physician will provide this information within 15 business days from the receipt of Authorization. Your physician may charge a reasonable fee for preparing and furnishing this information according to rulings set forth by the Texas State Board of Medical Examiners. You may revoke this authorization, but you must send your physician a written revocation of the Authorization. Your physician can provide you a revocation form. This authorization will expire 30 days from the date of the signature unless otherwise requested.

I understand that I have the legal right to revoke this Authorization in writing, except for disclosures made as a condition of obtaining insurance coverage and have been informed of how I may revoke the Authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by the medical privacy laws.

I have read and understand this consent, and I have signed it voluntarily and of my own free will.

Signed: _____

Relationship to Patient: _____

Date: _____, 20_____

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.