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AUTHORIZATION TO DISCOLE HEALTH INFORMATION
MEDICAL RECORD REQUEST

I hereby authorize the use or disclosure of information from the medical record of:
PATIENT NAME: _____DOB: _____ACCOUNT #_____

I authorize the following individual or organization to disclose the above individual's health information:
_____Address: _____
Phone: _____Fax:_____
This information may be disclosed to and used by the following individual or organization:
SAN ANTONIO ENT Address: _____
For the purposes of: _____
Please release the following: (Note: list not required by HIPAA)
____Entire record
OR:

_____Problem list	____X-ray/Imaging Reports-from (date)_____ to (date)_____
_____ Progress Notes	____X-ray Films
_____History/Physical Exam	____Laboratory Results-from (date) _____to (date)_____
_____Medication list	____EKG reports
_____Immunization Record	____Genetic Testing information
_____List of Allergies	____Other Diagnostic Reports (Specify)_____
	____Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include behavioral or mental health services, and treatment for alcohol and drug abuse.
_____Yes, I consent to the release of this information _____No, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

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 and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to ensure treatment. I understand that I may request a copy of 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 rules. If I have questions about disclosure of my health information I may contact the office.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship of Patient (if Legal Representative) Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent by misunderstanding of the information contained. I will not hold **SAN ANTONIO ENT** for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (if Legal Representative) Date

Date request completed _____ # of pages copied _____ Reviewed only_____
Charges $_____ Cash_____ Check#_____ Initials_____