Authorization for Disclosure of Medical Information

Patient Name_____ DOB_____
Address_____
_____Telephone Number_____

The undersigned hereby waives right to the privilege if confidentiality and authorizes Texas ENT Specialist P.A. to 'disclose' that is, release and provide a copy, summary, or narrative of your protected health information (otherwise known as your medical records) to the person(s) or entity listed below.

_____( ) _____-_____
Name of person(s) or company/facility to receive information Telephone number w/area code

( ) _____-_____
Fax number w/area code

_____
Street address City State Zip Code

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

The disclosures made under this authorization are subject to limitations indicated below (check one)

_____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:
_____

We will provide this information within 15 business days from the receipt of Authorization. We 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 a written revocation of the Authorization. We can provide you a revocation form. This authorization will expire in 30 days from the date of signature unless otherwise requested.

I understand that I have the 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 of this Authorization may be subject to re-disclosure by he recipient and no longer be protected by the medical privacy laws.

I have read and understand this consent, and I have signed in voluntarily and of my own free will. TexasENT Specialists, P.A. and its employees are hereby released from legal responsibilities or liability for the release information contained in the medical record.

SIGNED_____

RELATIONSHIP TO PATIENT_____

DATE_____

Any disclosure of medical record information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.

If you have any questions about this or any other matter
Please feel free to call us at 281-897-0416