THE BARRANCO CLINIC
Otolaryngology-Head & Neck Surgery
Allergy • Facial Plastic & Reconstructive Surgery

Authorization For Release of Protected Health Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security: _____ Home Phone: _____

I hereby request and authorize the following:

The Barranco Clinic
160 East Lake Howard Drive
Winter Haven, Florida 33881
Phone (863) 299-1251 Fax (863) 299-7666

To release to: _____

_____

_____

_____

_____ A complete copy of all of the above named patient's medical records, including all records to mental health, drug, or alcohol conditions, or HIV status, if applicable.

_____ A copy of the above named patient's medical records, limited to the following: _____

_____

_____ Actual X-ray films or copies: We understand that these films are a part of your permanent record and are released on a loan basis only. We will return the films after our review of them.

The purpose of this disclosure and release is _____.

I hereby release _____ and its employees, agent, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this consent for release of medical information.

This authorization and request shall be valid until the disclosure is complete or up to 90 days after the date below, after which time it shall expire. This authorization may be revoked by submitting a written revocation to The Barranco Clinic at any time.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PATIENT REPRESENTATIVE OR GUARDIAN SIGNATURE (IF PATIENT IS LESS THAN 18) RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT

_____
WITNESS SIGNATURE

_____ Patient has been advised regarding the costs for copying medical records.

Requestor's Signature: _____