

Ear, Nose & Throat Center of Austin

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the release of information in or related to the medical record or care of:

Name of Patient _____ DOB _____ SS# _____ (optional)

I authorize the following person or entity to release medical records/information on the patient listed above:

Name: _____ Address: _____ Fax: _____

TO the following person or entity:

Name: _____ Address: _____ Fax: _____

Reason for release: _____

Please release the following:

___ ALL Records

Or:

- ___ Problem List
- ___ Progress Notes
- ___ History/Physical Exam
- ___ Medication List
- ___ Immunization Record
- ___ List of Allergies
- ___ Audio (Hearing Tests)

- ___ X-Ray/Imaging Reports Date: _____
- ___ Hearing Tests/Audio Results
- ___ Laboratory Results Date: _____
- ___ ENG/VNG
- ___ Sleep Study
- ___ Other Diagnostic Reports (Specify) _____
- ___ Other (Specify) _____

I understand that information included may include information relating to STD's, AIDS, or HIV. It may also include information about 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 written consent of the patient is prohibited.

I understand that I have the 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 person or entity 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 contest a claim under my policy. Unless otherwise revoked, this authorization expires on completion of this request or upon the following date: _____.

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 my misunderstanding of the information contained in these entries. I will not hold Ear Nose & Throat Center of Austin liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

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

Signature of patient (Guarantor): _____ Date: _____

Relationship to Patient: _____

For Internal Use Only			
Date Received _____	# pages copied _____	Payment Amount _____	Payment Rec'd _____
MD Approval _____	Employee Initials _____	Fax/Send Date _____	