**ENT & ALLERGY 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 | ___ List of Allergies | ___ X-Ray/Imaging Reports Date:_____ |
| ___ Progress Notes | ___ Audio (Hearing Tests) | ___ Laboratory Results Date: _____ |
| ___ History/Physical Exam | ___ ENG/VNG | ___ Other Diagnostic Reports (Specify) _____ |
| ___ Medication List | ___ Sleep Study | _____ |
| ___ Immunization Record | ___ Hearing Tests/Audio Results | ___ 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_____