SOUTH TEXAS ENT CONSULTANTS, PA
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AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Please Print) ______________________ Date of Birth ______________________

Street Address City State Zip ______________________ Telephone ______________________

Maiden name or other name used for records ______________________ Social Security Number ______________________

I hereby authorize ______________________ (*Name of Provider*), to Release to ______________________ (*Name*)

______________________ (*Address*)

The following information from my records:

- ❑ Complete Health Record(s)
- ❑ History & Physical
- ❑ Consultations
- ❑ Radiology Reports
- ❑ Operative Report
- ❑ Laboratory Report
- ❑ Audiology Reports
- ❑ Progress Notes
- ❑ Discharge Summary
- ❑ Billing Records
- ❑ Other ______________________

I ❑do ❑do not (check applicable box) authorize this information to be faxed. If yes, fax number: ______________________

Covering the period(s) From: ______________________To: ______________________

______ I understand that this authorization may include information relating to:
(*Initial*)

- ✓ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- ✓ Psychiatric Care
- ✓ Treatment for Alcohol and/or Drug Abuse
- ✓ Genetic Testing

If any, except as specifically stated here: ______________________

This information is to be disclosed for the purpose of ______________________

I UNDERSTAND THAT THIS AUTHORIZATION MY BE REVOKED IN WRITING AT ANY TIME, except to the extent that action has been taken in reliance on this authorization for the purposes stated above. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE IN NINETY (90) DAYS FROM THE DATE OF SIGNATURE.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I may inspect or copy any information to be used or disclosed under this authorization. I understand that South Texas ENT Consultants' records may contain information created by an entity other than South Texas ENT Consultants and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by South Texas ENT Consultants concerning me, including incorporated records. I acknowledge that South Texas ENT Consultants has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release South Texas ENT Consultants and its employees from all legal responsibility of liability that may arise from the act I have authorized above. South Texas ENT Consultants is not responsible for completeness, legibility, or omissions caused by the copying of any medical records from another institution.

______________________ *Signature of Patient or Legal Representative* ______________________ *Relationship to Patient* ______________________ *Date*

______________________ *Printed Name of Patient's Representative*

Prohibition on Re-disclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical and other record information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined or imprisoned.

- ✓ Original or copy of this authorization shall be filed in the patient's medical record.