

ASSOCIATES OF EAR, NOSE & THROAT SURGERY

Authorization to Release Medical Records to Our Office

PATIENT _____ DATE OF BIRTH _____

Medical Records released from:

Name/Facility _____ Specialty _____
Address _____
Phone (_____) _____ Fax (_____) _____

Medical Records released to:

Associates of Ear, Nose & Throat Surgery
324 West Main, Suite 100 Lewisville, TX 75057
Phone (972) 420-7212 Fax (972) 420-8812

Dates of Treatment, Admission or Discharge:

Medical Records to Include:

- | | | |
|--|--|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Operative Reports & Pathology | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Diagnostic Testing & Results | <input type="checkbox"/> Audiology Reports |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Other _____ | |

Please initial to authorize inclusion of information pertaining to the diagnosis and/or treatment of AIDS, HIV testing, psychiatric illnesses, and alcohol or chemical abuse and dependency. I understand that records pertaining to this information will not be released unless I have given my specific consent to release this information.

- ❖ I hereby authorize the above-named Physician/Facility to release the following information from the above named patient only to Associates of Ear, Nose & Throat Surgery. I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.
- ❖ I understand that a photocopy or facsimile of this authorization is valid as the original.
- ❖ I understand that I may revoke this authorization at any time by doing so in writing. Any disclosures given prior to any revocation will be permissible.

Signature of Patient, Parent or Legal Guardian

Date

Relation to Patient

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENTS(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.