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:

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Medical Records to Include:

☐ All Medical Records ☐ Operative Reports & Pathology ☐ Lab Results

☐ History & Physical ☐ Diagnostic Testing & Results ☐ Audiology Reports

☐ Office Notes ☐ 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

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Relation to Patient

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