ENT Specialists, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical records cannot be released until this form is completed and signed by the patient, parent, or legal guardian.

PATIENT INFORMATION: Name: Date of Birth:
Address:

I HEREBY AUTHORIZE ENT SPECIALISTS, INC. TO RELEASE: (Specify below what information is to be released.)

- ☐ ALL records
- ☐ All records, EXCEPT: _____
- ☐ ONLY Records relating to: _____
- ☐ Records between the following dates: From _____ To: _____
- ☐ **Sensitive Information** (Consent required, below, if sensitive information is to be released.)

  I AGREE TO THE RELEASE of the information in my medical record that relates to drug and/or alcohol abuse, history of psychiatric care, history of sexually transmitted disease, social service consultations, hepatitis testing/treatment, and/or other sensitive information.

  Signed: _____ Print Name: _____
  Patient parent legal guardian (circle one)

- ☐ **HIV Information** (Consent required, below, if HIV information is to be released.)

  I AGREE TO THE RELEASE of HIV information in my medical record.

  Signed: _____ Print Name: _____
  Patient parent legal guardian (circle one)

RELEASE THIS INFORMATION TO:

- ☐ Patient, parent, or legal guardian
- ☐ Other: Name: _____
  Last Name First Name
  Address: _____
  Address City State Zip

STATEMENT OF UNDERSTANDING AND ACCEPTANCE

Your signature indicates that you agree to the disclosure or release of medical information described above and that you understand and accept the following:

- This authorization is valid for 90 days from the date of signature
- This authorization may be revoked at any time by sending a written request for revocation to ENT Specialists, Inc. This revocation will not affect any actions taken by the releasing provider before my written revocation is received.
- Your medical treatment cannot and will not be dependent upon your signing this authorization.
- The medical information that is the subject of this form may not be protected by the federal privacy regulations if or when it is redisclosed by the person, group, or institution you are authorizing to receive it.
- You have the right to receive a copy of this authorization.
- You have the right not to sign this authorization.
- Restrictions that you place on the release of information may delay or prevent the release of information and may have a negative impact on your care by other medical professionals.

Signed: _____ Print Name: _____
Patient parent legal guardian (circle one) (If person signing is not the patient)

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_____, M.D. Date: