FAMILY EAR, NOSE AND THROAT CLINIC, P.C. ent

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Authorization for Release of Medical Records

Patient Name _____ Date _____

ADDRESS _____ SS# _____

_____ Birth Date _____

Receive Records from

_____

_____

_____

Release Records to

_____

_____

_____

Please send me a copy of my records as indicated for the dates of treatment:

_____

Purpose for releasing medical information.

_____

_____
Signature of Patient, Parent or Legal Guardian

_____
Witness

_____
Date

I understand that my express consent is required to release any health information relating to testing, diagnosis or treatment of alcohol- or drug-related medical problems, and this special consent will also apply to HIV- or AIDS-related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42C.F.R. Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but is not retroactive to the release of information made in good faith.

_____
Signature of Patient,

_____
Witness

Permission to fax records for a medical emergency? _____ ☐ Yes ☐ No

This authorization expires 90 days from the date of signature authorization.