1441 Redbud Blvd Suite 211 McKinney, TX 75069
Phone (469) 678-2211 ♦ Fax (469) 678-2253

Authorization for Release of Medical Records

Patient Information: (Please print clearly)

Name:	**SSN:**
Address:	**DOB:**
City, State, Zip:	**Telephone number:**

Information Releases From:	**Information Released To:**
Name of Clinic/Physician:	**Name of Clinic/Physician:** Texas Ear and Vestibular Institute
Address:	**Address:** 1441 Redbud Blvd. Suite 211
City, State, Zip:	**City, State, Zip:** McKinney, Tx 75069
Phone Number:	**Phone Number:** 469-678-2211
Fax Number:	**Fax Number:** 469-678-2253

TYPE/EXTENT OF RECORDS TO BE RELEASED:

☐ **Records pertaining to:** ____

☐ **Entire patient records**

- I understand that this authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here ___________.
- I may revoke this authorization by notifying Texas Ear and Vestibular Institute in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that a photocopy or facsimile of this authorization will be considered as valid as the original.
- I will be fully responsible for any delay caused by failure to complete this form accurately and entirely.
- I understand that a copy of the requested records will be sent to the destination I have specified.
- Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I hereby acknowledge that I have read and fully understand the above statement as they apply to me. I consent to the release of records for the purpose stated above.

____ Signature of Patient

__________________ Date