ALLERGY EAR NOSE & THROAT CLINIC OF NORTHEAST TEXAS

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

_____ DOB: _____ SSN: _____
(Print name of patient)

Information to be released from: _____ Fax: _____

_____ Phone: _____
(Name of designated facility or provider)

_____
Address City State Zip Code

Information to be sent to: _____ Fax: _____

_____ Phone: _____
(name of facility or provider)

_____
Address City State Zip Code

Information to be released:

- The most recent 2years of information (doctors notes, labs, xrays & special test)
- All Medical Records
- Specific information (please specify) _____

Purpose for which disclosure is being made:

- Attorney
- Doctor
- Insurance
- Personal
- Transfer of care

I understand that my records may contain information regarding diagnosis or treatment. I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it at which time it may no longer be protected under privacy laws. I understand that fees may be charged for preparing and sending copies of the records, including charge for labor and supplies up to $25.00 for the first 10 pages and additional $0.25 for each additional page. Allergy ENT Clinic is not responsible for completeness or legibility caused by the copying of any medical records from another institution.

_____
Signature of patient or patient's representative Date