Medical Record#_____ Amt Paid $_____
FOR STAFF USE ONLY

fort worth ent
EAR NOSE & THROAT

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Street Address: _____ City, State, Zip: _____

Phone Number: _____ E-mail Address: _____

I request and authorize _____ to

release healthcare information of the patient named above to: _____

*Please fill in information below for entity that is **NOT** Fort Worth ENT:*

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

Record Copy Delivery: ☐ Pick-Up ☐ Mail ☐ Fax to healthcare office ☐ E-mail

Purpose of the use and/or disclosure: ☐ Continued Care ☐ Legal Insurance ☐ Personal Use ☐ Other: _____

I hereby authorize Fort Worth ENT, PA to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my healthcare and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying, in writing, the office where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand that there is a charge for photocopies and records provided, as permitted by Texas law, unless copies are sent directly to another healthcare provider.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.