



Medical Record# _____ Amt Paid \$ _____

FOR STAFF USE ONLY

Jeremy P. Watkins, MD
J. Brad McIntyre, MD
Sean M. Callahan, MD
Jordan McNeill, APRN, ACNP

1250 8th Ave, Ste 135 | Fort Worth, TX 76104
Phone: 817.332.8848 | Fax: 817.335.2670

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
 Continued Care Legal Insurance Personal Use
Purpose of the use and/or disclosure: 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.