The Ear, Nose, Throat & Plastic Surgery Associates

FAX COMPLETED FORM TO: 407-644-3697

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize:_____
(Physician Releasing Records)

_____
(Street Address) (City, State, Zip Code)

_____
(Phone Number) (Fax Number)

to release medical, psychiatric, drug use, alcohol abuse, HIV testing, AIDS Related Complex (ARC), or AIDS information* in the records of the patient named below for the purpose of medical care:

*Any of the categories above may be deleted by marking through

TO: _____
(Patient, Physician or Other Name)

_____
(Street Address) (City, State, Zip Code)

_____
(Phone Number) (Fax Number)

Place your initials by each item to be released:

__ Complete Medical Record __ Office Notes: Date Range from:_____to:_____ __Operative Reports

__Pathology Reports __ Radiology Reports __ Sleep Studies __ Audiograms and/or Audio Tests

__ Other, please specify:_____

I understand that this consent is revocable upon written notice, except to the extent that action has been taken in reliance on this authorization, and that this authorization shall remain in force for 5 years in order to effect the purpose for which it is given. ***A signed authorization must be completed for each records release request.***

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal regulation 42 CPR part II prohibits making any further disclosure of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing, AIDS Related Complex (ARC), and/or AIDS related diagnosis is further prohibited from further disclosure by state regulations without the specific written consent from the patient.

_____
Date of Authorization

_____
Patient's Name

_____ _____
Patient's Date of Birth Patient's Social Security Number

_____ _____
Signature of Patient, Parent, or Legal Guardian Relationship to Patient

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For Office Use Only

_____
Physician/Office Manager Authorizing Signature