ALLERGY & ENT ASSOCIATES

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

SECTION 1: Patient Information (please print and complete ALL fields)

First Name: _____ Last Name: _____ Date of Birth: _____/_____/_____

Address: _____City/State/ZIP: _____ Phone: _____

SECTION 2: Information Requested (please check all appropriate boxes)

I request the following information to be released, which may include: alcohol/drug treatment, mental or behavioral health; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; genetic information and demographic information.

*Please indicate the specific type of information to be disclosed. ("All records" or incomplete dates are not considered specific.)
Charges may apply. Please contact us for details. Cash payments are not accepted.

☐ Complete Medical Records ☐ Progress/Physicians Notes ☐ Radiology Reports ☐ Radiology Images (CD) ☐ Lab/Path Reports

☐ Operative Reports ☐ Audio Reports ☐ Billing Statement ☐Other:_____

*For the following dates of treatment:
_____ (Examples: specific date - 1/25/2013; range of dates - January-July 2014)

SECTION 3: I authorize Allergy & ENT Associates to release the above patient records to:

Name of Individual/Organization: _____ Phone: _____

Address: _____ City/State/ZIP: _____ Fax: _____

SECTION 4: Method of Delivery ☐ Fax ☐ U.S. Mail ☐ Secure e-Delivery Email

Address: _____☐ Call for pickup by patient or legal representative (***photo ID is required for pickup***)

SECTION 5: Purpose of Disclosure ☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Transfer of Care (Permanently Leaving) ☐ Legal ☐ Other: _____

- I understand I have the right to revoke this authorization in writing at any time by sending revocation to Allergy & ENT Associates at 450 Gears Rd. Ste #420 Houston, TX 77067. The revocation will not apply if Allergy & ENT Associates has already acted in reliance on the authorization
- I understand this authorization will expire in 90 days or upon the following specified date or event: _____
- I understand information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.
- **I understand that disclosure will include Mental Health, HIV/AIDS/STD, and Genetic Testing and Drug/Alcohol Abuse information (refer to Section 2 above).**
- I understand I have the right to refuse to sign this authorization, and Allergy & ENT Associates does not condition treatment on this authorization, except disclosure necessary for payment of claims (excluding psychotherapy notes) or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).

I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.

Patient Signature: _____ Date: _____

Representative Signature (for minors, etc.):_____ Relationship: _____ Date: _____