ALLERGY & ENT ASSOCIATES

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
## Medical Record Fax Number: 713-800-0253

### SECTION I: PATIENT INFORMATION

**PATIENT FIRST NAME:** _____ **PATIENT LAST NAME:** _____

**DATE OF BIRTH:** _____ **PHONE NUMBER:** _____

**ADDRESS:** _____ **CITY/STATE/ZIP:** _____

### SECTION II: INFORMATION REQUESTED

**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.) PLEASE CHECK ALL APPROPRIATE BOXES.

*Charges may apply. Please contact us for details. Cash payments are not accepted.*

| | | | |
|---|---|---|---|
| ☐ | COMPLETE MEDICAL RECORDS | ☐ | PROGRESS/PHYSICIAN NOTES |
| ☐ | RADIOLOGY REPORTS | ☐ | RADIOLOGY IMAGES (CD) |
| ☐ | LAB/PATH REPORTS | ☐ | OPERATIVE REPORTS |
| ☐ | AUDIO REPORTS | ☐ | BILLING STATEMENT |
| ☐ | OTHER: | | |

FOR THE FOLLOWING DATES OF TREATMENT: _____

*(Specific date: 1/1/2000 or range of dates: January-July, 2000)*

### SECTION III: AUTHORIZATION

I AUTHORIZE ALLERGY & ENT ASSOCIATES TO RELEASE THE ABOVE PATIENT RECORDS TO:

**NAME OF INDIVIDUAL/ORGANIZATION:** _____

**PHONE NUMBER:** _____ **FAX NUMBER:** _____

**ADDRESS:** _____ **CITY/STATE/ZIP:** _____

### SECTION IV: METHOD OF DELIVERY

| | | | |
|---|---|---|---|
| ☐ | FAX | ☐ | US MAIL |
| ☐ | SECURE DELIVERY EMAIL | ☐ | CALL FOR PICKUP BY PATIENT OR LEGAL GUARDIAN (PHOTO ID REQUIRED) |

**ADDRESS:** _____

### SECTION V: 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. Suite 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 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 II 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):** _____

**RELATIONSHIP:** _____ **DATE:** _____