Allergy & ENT Associates
Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records:

Initial: _____ Date: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

Release my protected health information FROM the following person(s)/entity:

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Fax: _____ **Phone:** _____

TO the following person(s)/entity:

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Fax: _____ **Phone:** _____

The reasons or purposes for this release of information are as follows:

_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners. I understand that I may revoke this consent at any time and this authorization expires automatically in 90 days.

_____ _____

Patient Name (Please PRINT) **Date of Birth**

_____

Patient Signature [or parent, guardian or legal representative]:

Date: _____ **Witness:** _____