Authorization to release healthcare information

1. Patient information

_____ _____

Name of patient: Date of birth:

_____ _____

Street address City, state, ZIP Code

_____

Phone number

2. Authorize:

_____

Name of physician/healthcare facilities

_____

Street address

_____

City, state, ZIP Code

_____

Phone number/fax number

3. Release protected health information to:

_____

Name of physician/healthcare facility

_____

Street address

_____

City, state, ZIP Code

_____

Phone number/fax number

4. Propose or need for disclosure: (check applicable categories)

[ ] transferring to new physician/continued medical care (customary to release up to two years of most recent information) [ ] personal use [ ] insurance eligibility/benefits [ ] disability determination [ ] legal investigation

5. Health information to be released

Office visits: [ ] specialty (specify)_____ [ ] procedures [ ] lab reports [ ] imaging reports

[ ] pathology reports [ ] specific information related to: _____

For the following date(s) or timeframe from:___/__/____ To: ___/___/_____

5 a. Federal state law requires special permission to release certain information. Please check it is record should be released.

6. Signature

I understand that this authorization is voluntary. And confirming my authorization that West Texas ENT and sinus may use and/or disclose to the persons and/or organizations named in this form the protected health information in this form. I understand that the signed request will expire within one (1) year from the date of my signature below list date specified.

Signature: _____ Date: _____

If this authorization is signed by representative on behalf of the patient, please complete the following:

Representative's name:_____

Relationship to the patient: _____

For office use only:

Request sent:_____ Request versus initials:_____ Date received:_____

Date processed:_____ Processed by:_____

Information: [ ] Mailed [ ] Picked up [ ] Faxed to ( ) _____

ID verified [ ]Yes [ ] No