

Authorization for Disclosure of Confidential Information
SOUTHWEST ENT ASSOCIATES

I hereby authorize the release of information from the medical record of:

Patient Name _____

Address _____

Date of Birth _____ Social Security # _____

I authorize SouthWest ENT Associates, P.A. to release medical information to:

Name of person/facility _____

Address _____

This information is necessary for the following purpose:

- | | | |
|---|---|---|
| <input type="checkbox"/> Continued Patient Care | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Attorney/Legal |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (Specify): _____ | |

Check all that may be released:

- Complete medical record - A fee of \$25 for the 1st 20 pages which includes postage charges. Please enclose a check payable to SouthWest ENT. Additional pages are .15 cents per page. This fee is in compliance with Texas State Board of Medical Examiners rules regarding fees for medical records.
- History/Physical Lab Reports/X-ray Operative Report
- Progress Notes Audiogram Other (please specify) _____

You will be notified of the fee for partial records prior to the record being duplicated. Please note: Due to patient confidentiality law, medical records can not be sent by fax except in cases of medical emergency.

This authorization covers patient care given from _____ to _____

Informed Consent for Release of Confidential Information:

I understand that:

I may revoke this consent in writing at any time except to the extent action has already been taken
This consent will expire 180 days after the date of my signature unless otherwise specified
I understand that there is a fee for copy services rendered and payment of the fee is due prior to my records release.
I understand that this information may include HIV/AIDS, Mental Health & Chemical Dependency diagnosis, treatment & test results
I understand that the information released is for the specific purpose stated above.
I understand that my medical records may contain reports that only a physician can interpret.
I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries
I will not hold SouthWest ENT Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation
I understand that within fifteen (15) business days of receipt of payment, my records will be available

The patient agrees that a photocopy of this authorization may be considered valid: Yes No

Patient Signature _____ Date _____

If patient is a minor, relationship to the patient: _____