**Central Park ENT & Surgery Center**

**Authorization form for Release of Protected Health Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release my Protected Health Information (PHI) to: **Central Park ENT & Surgery Center**

**Arlington Location: Dallas Location: Fort Worth Location: Mansfield Location:**

409 Central Park Drive 3131 Turtle Creek Blvd 800 Eighth Ave. 221 Regency Pkwy.

Suite 302 Suite 618 Suite 111

Arlington, Texas 76014 Dallas, Texas. 75208 Fort Worth, Texas. 76104 Mansfield, Texas. 76063

817.261.9191 972.884.5606 817.335.6336 817.592.8408

817.784.6880 Fax 817.784.6880 Fax 817.784.6880 Fax 817.784.6880 Fax

**Dana B. Gibbs, M.D. Chris T. Lee, M.D. Rene M Pena, M.D. Stuart N. Thomas, M.D.**

**Tyler W. Scoresby, M.D.**

**The reason or purposed for this release of information are as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

History and Physical Pathology Reports Hospital Notes Clinic Notes Radiology Reports

Hospital Discharge Summary EKG’S / ENG’S Operative Reports Billing Statements

This authorization will expire one year form the date of signing unless I indicate an earlier date or event here: I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to: **Central Park ENT & Surgery Center.**

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal HIPPAA privacy regulations.

**Attention:** This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

* If the patient is 18 years of age or older, the patient must sign and date the form.
* If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sing and date the form. Please indicate your legal authority and include documentation of your relationship:

\_\_\_\_\_\_\_\_ Self \_\_\_\_\_\_\_\_Parent \_\_\_\_\_\_\_\_ Legal Guardian

Signature of Patient or Personal Representative (Required) Date

Printed Name of Person Signing (If not Patient)