Central Park ENT & Surgery Center

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of: _____

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Social Security #_____ (optional)

I authorize the following individual or organization to disclose the above name individual's health information: **Central Park Ear, Nose, Throat & Central Park Surgery Center** Address: **409 Central Park Dr. Arlington, Texas 76014**

This information may be disclosed to and used by the following individual or organization: _____

_____ Address: _____

Phone number: _____ Fax: _____ For the purpose of: _____

_____

Please release the following:

☐ Problem List ☐ Progress Notes ☐ History/Physical Exam ☐ Medication List

☐ Immunization Record ☐ List of Allergies ☐ X-Ray Films ☐ EKG Reports

☐ X-Ray/Imaging Reports-from (date) _____ to (date) _____

☐ Laboratory Results-from (date) _____ to (date) _____ ☐ Genetic Testing Information

☐ Other Diagnostic Reports (Specify) _____

☐ Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ YES, I consent to the release of this information. ☐ NO, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not app[y to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sing this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for

an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____ (insert privacy officer or other individuals name or contact information).

_____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes 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 ***Central Park Ear, Nose, Throat & Surgery Center*** *liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.*

_____

Signature of Patient or Legal Representative *Date*

_____

Relationship to Patient (If Legal Representative) *Witness*

Date requested completed_____ #of pages copied _____ Reviewed only _____ Initials _____

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