# THE EAR, NOSE AND THROAT CLINIC & HEARING CENTER
## AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

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| **PATIENT INFORMATION** | Name: ______________________________ Date of Birth: ______________<br>Address: ______________________________ Phone: __________________<br>City: ____________________ State: ____________ Zip Code: __________ |
| **WHO HAS THE INFORMATION YOU WANT RELEASED?** | Name: ______________________________ Fax: ______________<br>Address: ______________________________ Phone: __________________<br>City: ____________________ State: ____________ Zip Code: __________ |
| **WHO IS THE RECEIVING PARTY?**<br>Where do you want the information sent? | Name: ______________________________ Fax: ______________<br>Address: ______________________________ Phone: __________________<br>City: ____________________ State: ____________ Zip Code: __________<br>Fax Number: ____________________ (patient care provider only) |
| **INFORMATION TO BE RELEASED**<br>What do you want sent? Please check the correct box | ___ Billing Records<br>___ Audiology Tests<br>___ Radiology Reports<br>___ Laboratory Reports<br>___ All Records<br>___ Progress/Clinic Notes<br>___ Only those records between the following dates ____________ to ____________<br>___ Only those records relating to the following illness |
| **RELEASE INSTRUCTIONS**<br>How and When do you want the information? | Release Method / Format requested:<br>___ Paper<br>___ Fax (for patient care only)<br>___ Electronic<br>___ Verbal<br>Needed by ________________________ |
| **PURPOSE OF THE RELEASE**<br>Why is it needed? | ___ Continuing Care<br>___ Transfer of Care<br>___ Litigation<br>___ Insurance Application<br>___ Personal Use<br>___ Other ___________________________ |

- This authorization lasts for one year after the date that you sign it unless you enter a different date here: ____________
- This authorization can be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Please ask us how to cancel this authorization.
- A photo copy of this authorization will be treated in the same way as an original.
- Released records may include records that were received from other organizations if these records have been filed in the record maintained about you.
- Redisclosure of your information by the person or organization who receives your records under this authorization cannot be prevented and may not be covered by state and federal privacy protections after it is released. By signing this authorization you release ENTHC from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand the forms and authorize the release of your information.

________________________________________ ____________ ______________________

*Patient or Legal Guardian Signature* *Date* *Relationship*