



AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION
THIS RELEASE MUST BE FAXED TO (502) 371-4017

Patient Name: _____ Telephone: _____

Address: _____

SS#: _____ Date of Birth: _____

I hereby authorize ADVANCED ENT and ALLERGY to **send/obtain** my protected health information as follows:

Information disclosed from: _____

Information disclosed to: _____

Method of Disclosure: Copies Picked Up Copies Faxed to: _____

Copies Mailed Other: _____

Mark those that apply. Cross out any item you do not authorize to be released.

- Entire record, including mental health, HIV, and/or substance abuse records.
- Records regarding treatment for the following condition or injury: _____
- Records covering the period of time _____ to _____
- Immunotherapy - Vaccine/Biologics

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to our Site Administrator at ADVANCED ENT and ALLERGY. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that ADVANCED ENT and ALLERGY may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires one year from signature date. I certify that I have received a copy of this authorization. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature of patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority