AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Redlands: (909) 793-2500 | Banning: 951-769-6774

I authorize the following protected health information to be released from the medical record of:

Last Name (please print) _____ First Name (please print) _____ Date of Birth _____

Social Security Number _____ Home Telephone _____ Alternate Phone _____

RELEASE RECORDS

☐ To
☐ From

Premier ENT
255 Terracina Suite 201
Redlands, CA. 92373

☐ To
☐ From

Name/Organiztion _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____

☐ Please mail my records
☐ Please fax my records
☐ Please call when my records are ready for pick-up

REASONS FOR RELEASE OF INFORMATION

☐ At the request of the individual
☐ Other (if other, describe reason for disclosure)

_____

_____

INFORMATION TO BE RELEASED

☐ Entire record
☐ Specific information desired _____

or Texas
privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

** I understand that this authorization is valid for six months unless I notify Austin Ent Associates otherwise. I may revoke this authorization in writing at any time except to the extent that Austin ENT Associates has already relied on this information. I understand that the records released may include information relating to Human Immunodefiency Virus (“HIV”) infection or Acquired ic
care. I understand the information will be provided to me within 15 days of my requests.

Note: If mailing or faxing this form, please include a copy of your photo ID.

Signature of Patient _____ Date _____

PLEASE FAX BACK TO