



**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 Premier ENT  
 From 255 Terracina Suite 201  
Redlands, CA. 92373

To Name/Organiztion \_\_\_\_\_  
 From 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 Immunodeficiency 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**