ENT Associates

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____ Previous Name (if applicable): _____

Contact Number: _____

I request and authorize the release of medical information:
FROM: _____

_____

_____

TO: _____
Please include an address and/or fax number.

_____

_____

This request and authorization apply to:

_____All healthcare information

_____Other (specific): _____

I understand that my expressed consent is required to release any healthcare information related to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment. This authorization automatically expires in six months from the signature date.

_____
Signature of patient or authorized representative Date

_____
Relationship or status, if signed by other than patient