ENT for Children

Authorization for Release of Protected Health Information

By signing below, I authorize ENT for Children, P.A. to **receive**/**disclose** (circle one) protected health information about my child **to**/**from** (circle one)

Physician/Clinic/Hospital/Other: _____

Address: _____

Pursuant to the requirements of the Texas Medical Practice Act, please be advised that the purpose or reason for this is as follows: _____

_____

Please initial each section to be released:

_____Entire Medical Records
_____Labs
_____Audiology
_____Office Visit Note
_____ Other

Will the patient (s) be returning to ENT for Children, P.A. ___Yes___No If no, why have you chosen to leave?

_____

Name of Patient(s)	Date(s) of Birth
_____	_____
_____	_____
_____	_____

Fees to Copy Records

$25 for the first 20 pages of medical records copied, $0.50 each additional page plus mailing cost. No charge for records sent to another physician.

I understand that I have the right revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer: Dianna Moore. I understand that the revocation will not apply to information that has already been released in response to this authorization. **I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 12 months from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign authorization. I need not sign form in order to assure treatment. I understand that I may inspect or obtain a copy of information to be used or disclose, as provided in CFR164,524. I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have read the above foregoing Authorization for Release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand that a copy of facsimile of this authorization is as valid as the original. I understand that I must provide proof of my identity when submitting this request.

_____ _____ _____

Parent/Legal Guardian Signature | Date | Relationship to Patient

_____ _____

Print Name | Phone

ENT for Children, P.A. and their employees or agents are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

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