THE CENTER FOR ENT
Sinus + Allergy + Hearing

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# Release of Medical Records

| Patient Information | |
|---|---|
| Patient Name: | Date of Birth: |
| Address: | Phone Number: |

I authorize the release of Protected Health Information (PHI) to the physician/facility below. Please include the following information from my medical records.

☐ Progress Notes ☐ Operative Reports ☐ Allergy Testing
☐ Consultation Report ☐ Radiology Reports ☐ Immunotherapy Records
☐ Discharge Summary ☐ Pathology/Lab Reports ☐ **ALL Health Information**

☐ Other (Specify): _

| Please send to: |
|---|
| |

Only patients or their legal representatives may request medical records. The purpose of this disclosure is for treatment and continued medical care. The PHI released may include communicable disease (AIDS or HIV), substance abuse and mental health treatment. I understand that this authorization is valid for one year from the date of this request and may be revoked in writing at any time. I understand that the PHI disclosed may be subject to re-disclosure by the person/party receiving my PHI and may no longer be protected by federal or state privacy laws.

## Authorization

_____ _____
Patient Signature Date

_____
Printed Patient Name