EXCELLENT
Allergy and Hearing Solutions

Authorization to Release Information

Name _____ **DOB** _____

_____	_____	_____	_____	(___)_____
Address	City	State	Zip Code	Phone Number

Name, Address, Phone Number and Fax Number of health provider or entity to release this information:

_____

_____

Name, Address, Phone Number and Fax Number of person(s) or category of person to whom this information will be sent:

_____

_____

Specific information to be released:

- ☐ **Complete Medical Record**
- ☐ **Office Notes**
- ☐ **Radiology Reports**
- ☐ **History and Physical**
- ☐ **Lab Reports**
- ☐ **ER Department Reports**
- ☐ **Operative Reports**
- ☐ **Other:**

This protected health or other information is being used or disclosed for the following purposes:

_____

I hereby authorize the use or disclosure of personal health information about me as described above. I understand if a request to inspect the record is made, nothing may be removed, taken apart, or noted in or on any portion of the medical record. I understand that if the person of entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such a person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of this office, I understand that I may revoke this authorization in writing any time, except to the extent that action has been taken by this office in reliance on this authorization, by sending written revocation to the office. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event of condition, this authorization will expire in one year.

I understand this authorization is voluntary and this office will not condition treatment, payment, enrollment of eligibility for benefits on this authorization. I understand and acknowledge that my medical record may contain information relating to Mental Health, Alcohol/Drug Abuse and /or Human Immune Virus/Acquired Immune Deficiency Syndrome, or other sensitive information, and I expressly consent to the release of any such information contained in the record designated above. This release is sufficient for the purpose of release of Alcohol/Drug diagnosis and treatment, HIV test results or diagnosis.

_____ _____

Printed Name of Patient or Personal Representative **Signature of Patient or Personal Representative**

Date _____

If the person signing the form is not the individual whose information is being disclosed, please indicate your relationship to that person:

- ☐ **Parent or legal guardian of a child under the age of 18.**
- ☐ **Personal Representative (please attach documentation, i.e. Power of Attorney, Court Order, Health Care Proxy).**