BAY AREA ENT
EAR, NOSE & THROAT SPECIALISTS

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AUTHORIZATION TO RELEASE HEALTH INFORMATION
I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

I understand this information is confidential and there shall be no further disclosure without the written authorization of the patient and his/her legal guardian.

Please release the following documents:

☐ Entire Medical Record ☐ Progress Notes ☐ Operative Reports ☐ Radiology/Imaging Reports
☐ Medication List ☐ Hearing/Audiology Reports ☐ Allergy Reports ☐ Lab/Pathology Reports
☐ Sleep Study Reports ☐ Problem(s) Listed:_____
☐ Other: _____

I understand that the information to be released may include: alcohol/drug treatment, mental or behavioral health, HIV AIDS, or ARC, communicable disease or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, genetic information and demographic information.

I authorize *Bay Area ENT Specialists* to ☐ RELEASE ☐ REQUEST the above-named health information to/from:

Individual/Organization: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Fax Number:_____

By signing this release, I understand:

- I will not hold *Bay Area ENT Specialists* liable for any misinterpretation of the information in my medical record as a result of not consulting my Physician for the correct interpretation.
- Authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I have a right to revoke this Authorization at any time by submitting a revocation in writing to *Bay Area ENT Specialists*. If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- The revocation will not apply to my insurance company where disclosure is necessary as the law provides my insurer with the right to contest a claim under my policy.

I have read and understand this consent, I have signed it voluntarily and of my own free will.

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Relationship to Patient Date

_____
Printed name of Parent/Legal Guardian

****Parent/Legal Guardian MUST be listed on the HIPAA form on file. Legal Documentation and ID is required.**