AUTHORIZATION FOR RELEASE OF INFORMATION (FROM DALLAS EAR INSTITUTE)

I HEREBY AUTHORIZE: DALLAS EAR INSTITUTE TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW, WHICH MAY INCLUDE INFORMATION CONCERNING COMMUNICABLE DISEASES SUCH AS HUMAN IMMUNODEFICIENCY VIRUS ("HIV") AND ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS"), MENTAL ILLNESS (EXCEPT FOR PSYCHOTHERAPY NOTES), CHEMICAL OR ALCOHOL DEPENDENCY, LABORATORY TEST RESULTS, MEDICAL HISTORY, TREATMENT, OR ANY OTHER SUCH RELATED INFORMATION. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION. I FURTHER UNDERSTAND THAT MY HEALTH CARE AND THE PAYMENT OF MY HEALTH CARE WILL NOT BE AFFECTED IF I DO NOT SIGN THIS FORM.

I UNDERSTAND THAT IF THE RECIPIENT AUTHORIZED TO RECEIVE THIS INFORMATION IS NOT A COVERED ENTITY, E.G. INSURANCE COMPANY OR NON-HEALTH CARE PROVIDER; THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL AND STATE PRIVACY REGULATIONS.

_____ _____

PATIENT NAME (PLEASE PRINT) DATE OF BIRTH

☐ ALL DATES OF SERVICE OR ☐ SPECIFIC DATE(S) OF SERVICE

☐ **COMPLETE MEDICAL RECORDS**	☐ RADIOLOGY REPORTS & FILMS	☐ CONSULTATION REPORTS
☐ VISITS & ENCOUNTERS	☐ OPERATIVE REPORTS	☐ BILLING RECORDS
☐ LABORATORY REPORTS	☐ REGISTRATION RECORDS	☐ OTHER: _____

INFORMATION TO BE RELEASED: (CHECK ALL THAT APPLY)

THE HEALTH INFORMATION DESCRIBED HEREIN SHALL BE **RELEASED TO**:

_____ _____ _____

NAME OF PERSON OR ENTITY (PLEASE PRINT) TELEPHONE FAX

_____

ADDRESS

DELIVERY METHOD: ☐ MAILING ADDRESS ☐FAX ☐ PICK UP RECORDS ☐OTHER: _____

I FURTHER UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THIS PRACTICE IN WRITING. I ALSO UNDERSTAND THAT THE WRITTEN REVOCATION MUST BE SIGNED AND DATED WITH A DATE THAT IS LATER THAN THE DATE ON THIS AUTHORIZATION. THE REVOCATION WILL NOT AFFECT ANY ACTIONS TAKEN BEFORE THE RECEIPT OF THE WRITTEN REVOCATION.

_____ _____

PRINTED NAME OF PATIENT, PARENT, OR LEGAL GUARDIAN DATE

_____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN