SouthEastern
Ear Nose & Throat
ALLERGY & SLEEP DISORDERS

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT INFORMATION

Name of Patient: _____ **Date of Birth:** _____

Address: _____

City, State, Zip: _____ **Phone:** _____

RECORDS REQUESTED

At my request, _____ **may release the following information:**
(Name of the entity)

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Diagnostic studies (list):
- ☐ Other (list):

ENTITY TO RECEIVE INFORMATION

Name: _____

Address: _____

City, State, Zip: _____ **Phone:** _____ **Fax:** _____

PATIENT RIGHTS

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Signature: _____ **Date:** _____
(Signature of Patient or Personal Representative)

Authority: _____
Description of Personal Representative's Authority (attach necessary documentation)

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