



Authorization for Release of Information

Patient Name: _____ Maiden/other name: _____

Street Address: _____

City, State, Zip: _____

Birth Date: _____ Soc. Sec. No.: _____

Home Phone: _____ Work Phone: _____

I, Authorize:	To Release to:
_____	_____
_____	_____
Phone/Fax	Phone/Fax

Information to be released: **(complete record unless specified)**

Information to be withheld and reason for withholding: **(“none” unless specified)**

Xray films: Yes No Specify: _____

Purpose of disclosure: _____

The information may be communicated in the following manner: Oral Written Fax

This authorization shall be in effect until revoked by me in writing. I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand Lone Star Ear, Nose, and Throat Care client's/patient's records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. I understand that Lone Star Ear, Nose, and Throat Care may not condition my treatment or payment of my bills on my decision to sign this authorization. **A photocopy is as valid as the original.**

Signature of Patient or Guardian _____ Date _____

Relationship to patient if unable to sign _____ Witness _____

VERIFICATION OF PATIENT IDENTIFICATION	
VERIFICATION PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF VERIFICATION PROCEDURE PERFORMED: