8230 Walnut Hill Lane
Building 3, Suite 420
Dallas, Texas 75231
P: (214) 265-0800
F: (214) 265-1027

6300 W. Parker Rd
Building 2, Suite 221
Plano, Texas 75093
P: (972) 378-3708
F: (972) 378-5385

Authorization for Disclosure of Confidential Information

RELEASE OF INFORMATION **FROM** SOUTHWEST ENT ASSOCIATES

Patient Name: ____

Mailing Address: ____

City: ___________________________ Zip Code: ______________________ State: __________________________

Phone Number: ____Date of Birth: _____ /_____ /__________

I authorize **SouthWest ENT Associates, P.A.** to **release** medical information **to**:

Name of Person/Facility: ____

Mailing Address: ____

City: ___________________________ Zip Code: ______________________ State: __________________________

Phone Number: __________________________________ Fax Number: __________________________________

This information is necessary for the following purpose(s):

_____ Medical Care _____ Attorney _____ Insurance _____ Personal Use _____Other: _______________

Check all that may be released:

_____ Complete Medical Record – A fee of $25 for the 1st 20 pages, which includes postage charges. Additional pages are .50 cents per page. This fee is in compliance with the Texas State Board of Medical Examiners rules regarding fees for medical records.

_____ History/Physical _____ Progress Notes _____ Care Plan

_____ Lab/Reports _____ EKG Report _____ OP Report

_____ Other (Please Specify): ____

You will be notified of the fee for partial records prior to the records being duplicated.

I understand that:

I may revoke this consent in writing at any time except to the extent action has already been taken.
This consent will expire 180 days after the date of my signature unless otherwise specified.
I understand that there is a fee for copy services rendered and payment of the fee is due prior to my record release.
I understand that this information may include HIV/AIDS, Mental Health & Chemical Dependency diagnosis, treatment & test results.
I understand that the information released is for the specific purpose stated above.
I understand that my medical records may contain reports that only a physician can interpret
I understand that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information.
I will not hold SouthWest ENT Associates liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.
I understand that within fifteen (15) days of receipt of payment, my records will be available.

The patient agrees that a photocopy of this authorization may be considered valid: **YES** **NO**

Patient Signature: ____ Date: ___________________________

If the patient is a minor, what is your relationship to the patient: ____