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

SouthWest ENT
ADULT & PEDIATRIC
EAR, NOSE & THROAT SPECIALISTS

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

Authorization for Disclosure of Confidential Information

RELEASE OF INFORMATION TO SOUTHWEST ENT ASSOCIATES

Patient Name: _____

Mailing Address: _____

City: _____ Zip Code: _____ State: _____

Phone Number: _____Date of Birth: _____ /_____ /_____

I authorize my medical information to be **released from**:

Name of Person/Facility: _____

Mailing Address: _____

City: _____ Zip Code: _____ State: _____

Phone Number: _____ Fax Number: _____

To **Southwest ENT Associates, P.A.**
8230 Walnut Hill Lane, Suite 420
Dallas, Texas 75231

Phone: (214) 265-0800
Fax: (214) 265-1027

Check all that may be released:

_____ History/Physical _____ Progress Notes _____ Care Plan
_____ Lab/Reports _____ EKG Report _____ OP Report
_____ Other (Please Specify): _____
_____

This authorization covers patient care given from _____ to _____

Purpose of Disclosure:

_____ Medical Care _____ Attorney _____ Insurance _____ Other: _____

This authorization shall be valid for 120 days from the date of signature. This patient can revoke this authorization in writing at any time prior to the expiration date.

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: _____