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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: ______________________________

BIRTH DATE: ______________________ SS#: ______________________

PLEASE OBTAIN INFORMATION FROM: ______________________
Provider/Clinic/Organization

ADDRESS: ______________________________

INFORMATION TO BE RELEASED TO: ______________________

ADDRESS: ______________________________

PURPOSE OF RELEASE: ______________________
Personal - Medical - Legal - Insurance - Job/School - Continuing Care

INFORMATION TO BE DISCLOSED: This authorization permits the above provider to disclose the following medical records:

- ❑ Medical records created at the direction of Reno ENT Specialists
- ❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)______________________

❑ I authorize the release of protected Health Information relating to:
HIV/Aids_____, Drug/Alcohol Addiction_____, Mental Health_____, Genetic Testing_____.

Unless otherwise specified below, I understand that this authorization shall expire 90 days from the request date. I request that this authorization expire on (specify date or event):______________________

I understand that the contents of my medical records will remain confidential and will be released **ONLY** upon the signing of a consent form.

I further release my physician and his office employees from any liability arising from the release of information to the person/agency designated above.

Patient's Signature: ______________________ Date:______________

Parent or Legal Guardian's Signature: ______________________

Relationship to Patient:______________________

ADDITIONAL PATIENT INFORMATION:

- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be rediscovered by the recipient and is no longer protected by this office.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.
- A copy is to be considered as valid as the original.
- I understand that I (or the person authorized to act on my behalf) is entitled to receive a copy of this authorization.
- Refusal to Sign/Right to Revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.
- Revocation: I understand that this Authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my health care provider's office at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____Pick-Up Records _____Mail Records _____FAX Records

Completed By:______________________

Date:______________________