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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPPA and applicable by Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all sections that apply to their decision relating to the use or disclosure of their protected health information.

Patient's Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email (optional):_____

I _____ authorize The Sinus and ENT Center of Texas to request / release my records from:

(Patient/Guardian Name)

Name:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____

- ○ Entire Medical Record
- ○ Sleep Study
- ○ Diagnostic Imaging Reports
- ○ Audiometry
- ○ Lab Reports
- ○ Other:_____
- ○ Last Visit Note
- ○ Recent Progress Note
- ○ Allergy Testing
- ○ Oncology
- ○ Billing/Claims
- ○ Continuity of Care
- ○ Allergy Records
- ○ Legal Purposes
- ○ Pathology Reports
- ○ School/Work Purposes
- ○ Operative Reports
- ○ Hospital Records

The individual signing this form agrees and acknowledges as follows:

- This authorization is voluntary. I understand that I have the right to revoke this authorization at anytime by writing to the healthcare provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal state or privacy laws.

Signature: _____ Date: _____ Signature of Witness: _____