ENT & ALLERGY
ASSOCIATES P.S.

AUTHORIZATION TO RELEASE RECORDS

To _____ (Name of provider you are requesting records from)

_____ (Address)

Re: _____ (Patient name)

_____ (Social security number and/or date of birth)

You are hereby authorized to disclose the information described in this authorization on the terms hereof:

1. The information to be disclosed is as follows: (Description of records to be released)

   _____

2. The name or specific identification of the person or class of persons to whom to disclose the information requested above. (Where to send your records)

   _____ (Name and/or facility name)

   _____ (Address and/or fax number)

3. The purpose for which the disclosure may be made (Check the one that applies)

   _____ a. At the request of the person(s) identified in no. 2. (Above); or

   _____ b. For the following purposes: _____

4. This authorization terminates after: _____

5. In signing this authorization, I understand all of the following:

   a. My right to revoke this authorization, the exceptions to my right to revoke and a description of how I may revoke the authorization are described in the Notice of Privacy Practices of the Provider, a copy of which I have received and reviewed;

   b. The Provider may not condition this provision of treatment, payment, enrollment in a health plan or eligibility for benefits on the completion of this authorization except as follows: _____

   c. The information disclosed pursuant to this authorization will not be subject to being disclosed again by the recipient, except as follows: _____

6. I acknowledge a receipt of a copy of this authorization as executed by me.

DATED this _____ day of _____ ,20 _____

SIGNED _____

**If a personal representative of the individual referenced above signs this authorization, the representative's authority to act for the individual is as follows:*

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