

ROSEWOOD ENT

OTOLARYNGOLOGY - HEAD & NECK SURGERY

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Authorization For Release of Medical Information

Dear Dr. _____:

I, (Patient Name) _____ (Date of Birth) _____

(Social Security No.) _____ hereby authorize **ROSEWOOD E.N.T., LLP**

to release a copy of my records as indicated below to:

Name/Facility: _____

Address: _____

Phone No.: _____ Fax No.: _____

_____ Complete Medical Record

_____ Complete Allergy Record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition _____

_____ Other _____

The above information is released/requested for the following purpose:

_____ Application for Insurance

_____ Transferring to another Doctor

_____ Doctors Review

_____ Other (Please state reason) _____

*(Article 4495B, Section 5.08(j) Texas revised Civil Statutes require that an authorization for release of medical records include "the reason or purpose stated for release.")

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that; in any event, this authorization expires automatically ninety (90) days from the day of signature.

Patient

Signature: _____ Date: _____

Please check if of the following applies:

Patient is _____ a minor/ _____ unable to consent because _____

Signature of Guardian/Legal representative _____

Witness Signature: _____ Date: _____

I also authorize the release of; if applicable, any mental health/psychological records, any treatment or test results for alcohol and/or drug abuse, or reportable communicable diseases including acquired immune deficiency syndrome or human immune-deficiency virus infection.

Signature for Release _____