The Ear Institute of Texas, P.A.

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18518 Hardy Oak Blvd, Suite 300
San Antonio, Texas 78258

AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

______________________________ Name of Patient (Please Print)   __________ Date of Birth   __________ Record #:

______________________________ Street Address   City   State   Zip   _(_______)__________________ Phone

______________________________ Maiden name or other name used for records   __________________ Practice Use: MedRec #

I hereby authorize   (Please Print)
____
____
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To Release to: ☐   Obtain from: ☐
EAR INSTITUTE OF TEXAS
18518 Hardy Oak Blvd, Suite 300
San Antonio, TX 78258

The following information from my records:

__ Complete Health Record(s)   __ History & Physical   __ Radiology Report/Films   __ Vestibular Test Results/Reports
__ Operative Report   __ Laboratory Report   __ Nuclear Medicine Reports   __ Physical Therapy Results/Reports
__ Progress Notes   __ Discharge Summary   __ Audiology Results/Reports
__ Other (please specify) ______________________________   **__ MRI/CT Report (Head/Neck ONLY)**

I do / do not (circle applicable) authorize this information to be faxed. If yes, fax number: _(210) 798-2509_________________

Covering the period from ____________________ to ____________________

____ (Initial) I understand that this authorization may include information relating to:

- ❖ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
- ❖ Psychiatric care
- ❖ Treatment for alcohol and/or drug abuse
- ❖ Genetic testing

If any, except as specifically stated here: ______________________________

This information is to be disclosed for the purpose of ______________________________

The date, extent or condition upon which this authorization expires is ___________ not to exceed 24 months (except for research purposes, state "**NONE**" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than **The Ear Institute of Texas, P.A.** and therefore **The Ear Institute of Texas, P.A.** is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by **The Ear Institute of Texas, P.A.** concerning me, including incorporated records. I acknowledge that **The Ear Institute of Texas, P.A.** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **The Ear Institute of Texas, P.A.** and its personnel form all legal responsibility of liability that may arise from the act I have authorized above. **The Ear Institute of Texas, P.A.** is not responsible for completeness, legibility, or omissions caused by the copying of any medical records form another institution.

______________________________ Signature of patient or patient's representative   ____________________ Date

Printed name of patient's representative ______________________________   Relationship to patient ____________________

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Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it permits. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall and will be fined or imprisoned.
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