ALABAMA
EAR, NOSE & THROAT
SPECIALISTS, LLC

AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

THIS RELEASE MUST BE FAXED TO THE APPROPRIATE LOCATION PROVIDED AT THE BOTTOM OF THIS PAGE

Patient Name: _____ Telephone: _____

Address: _____

SS#: _____ Date of Birth: _____

I hereby authorize Alabama Ear, Nose & Throat Specialists, LLC (ALENTS) to **send/obtain** my protected health information as follows:

☐ Information disclosed from: _____

☐ Information disclosed to: _____

Method of Disclosure: ☐ Copies Picked Up ☐ Copies Faxed to: _____

☐ Copies Mailed ☐ Other: _____

Mark those that apply. Cross out any item you do not authorize to be released.

☐ Entire record, including mental health, HIV, and/or substance abuse records.

☐ Records regarding treatment for the following condition or injury:

☐ Records covering the period of time _____ to _____

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to our Site Administrator at ALENTS. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that ALENTS may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires one year from signature date. I certify that I have received a copy of this authorization. This authorization expires ninety (90) days from the date of this signature.

_____ _____

Signature of patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

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