TEXAS ENT
& ALLERGY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
DATE OF BIRTH: _____

I, _____, hereby authorize

_____ to disclose my protected health information described below to:

_____

_____

for the purpose of:

_____

The protected health information to be disclosed is specifically described as follows:

_____

_____

_____

This authorization shall be in force and effective until the following event and/or date:

_____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Texas ENT & Allergy. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage.

_____ _____
Signature of Patient or Personal Representative Date

_____
Personal Representative's Relation to Patient