



**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