Vero ENT Associates

Board Certified Otolaryngology
Head & Neck Surgery

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Zip: _____
Phone: SSN #:

_____ _____

I authorize the custodian of records of Vero ENT Associates, LLC to disclose / release the following information* (check all that apply):

___ All Records
___ Billing Records
___ Pharmacy / Prescription
___ Laboratory / Pathology Records
___ Imaging Records
___ Other (describe specifically): _____

*NOTE: If these records contain any information from previous providers or information about HIV / AIDS, cancer diagnosis, substance abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Release Records from: _____
Name, Telephone & Fax #

Please send records indicated above to: _____
Name, Telephone, fax number and address if needed

Call for patient pick up: _____
Telephone number

This authorization shall expire 365 days from the date of signing and may not be valid for greater than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. By signing below, I represent and warrant that I have authority to sig this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient or patient's representative | Date

_____ _____
Printed name of patient's representative | Representative's relationship to patient
(e.g. parent, guardian, power of attorney for healthcare)

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