TEJAS
Ear, Nose and Throat, P.A.

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient for whom authorization is made:

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone: (_____)_____ Email (Optional): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Physician or Practice Name: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:

Full Name: _____

Address: _____ City: _____ _ State:_____ Zip:_____

Phone: (_____)_____ Fax: (_____)_____

Specific Information to be disclosed:

☐ Medical Record from (date) _____ to (date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, and records received from other health care providers.

☐ Other:_____

Include: (Indicate by Initialing)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AID-Related Information

_____ Genetic Information

Right to Revoke: *I have the right to revoke this authorization at any time by writing to the health care provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.*

Signature Authorization: *I have read this form and hereby authorize the release of my medical records and health information as described above:*

Signature: _____

Patient/Legal Representative Printed Name: _____

Relationship to Patient (if applicable): _____ Date: _____

Please submit this form via one of the following methods:

Email info@tejas-ent.com | ***Fax*** (855) 876-8593 | ***Mail*** P.O. Box 131, Georgetown, TX 78627