Hill Country Ear, Nose & Throat, P.A.

Otolaryngology & Sleep Medicine
Charles F. Lano, Jr., M.D.

Audiology
LeAnn Clements, Au.D.,CCC-A

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize: _____ to release health records information on:

Patient Name: _____ **Date of Birth: _____**

Address: _____ **Social Security #: _____**

_____ **Telephone #: _____**

For healthcare covering the period(s): From: _____ To: _____

To: _____ **Telephone #: _____**

Address: _____

_____

I □ **do** □ **do not** (check applicable box) authorize this information to be faxed. If yes, Fax Number: _____

Name of person to receive faxed information (if different than above): _____

This information is being disclosed for the following purpose(s) of: _____

_____

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

INFORMATION TO BE DISCLOSED (check appropriate box)

□ Complete health records □ Medical assessment/history □ Progress notes
□ Consultation □ Audiology reports □ Laboratory
□ X-ray/CT/MRI reports □ Billing records □ Other: _____

I understand this information may contain information relating to: (check if applicable)
□ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency virus)
□ Mental Health or □ Alcohol and/or Drug Abuse

REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION FOR THE PURPOSES STATED ABOVE.

UNLESS OTHERWISE INDICATED, THIS AUTHORIZATION WILL EXPIRE NINETY (90) DAYS FROM THE DATE OF SIGNATURE. THE PHYSICIAN AND EMPLOYEES ARE RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

I understand that there may be a fee for preparing and furnishing thus information.

_____ _____ _____
Signature of Patient or Legal Representative | Relationship to Patient | Date