TEXAS ENT CENTER

TEXAS ENT CENTER, PLLC

4601 Heritage Trace Parkway, Ft. Worth, TX 76244 • Phone: 817-431-7985 • Fax: 817-431-5031

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: ______________________________ Date of birth: ______________

I authorize: Texas ENT Center, PLLC, Stephen J. White, M.D., and Brandon L. Christianson, M.D., to disclose/release all medical records,* including any scans, MRIs, ultrasounds and hearing tests, to: ______________________________

______________________________ FAX (required): ______________

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

THE INFORMATION MAY BE USED/DISCLOSED FOR EACH OF THE FOLLOWING PURPOSES:

☐ At my request (only the patient can check this box)

☐ For my health care

☐ For payment/insurance

☐ For employment purposes

☐ Other: ______________________________

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This authorization shall expire 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 it. My refusal to sign will not affect my ability to obtain treatment, receive payment or qualify for benefits unless allowed by law. By signing below, I represent and warrant that I have the authority to sign 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 personal representative) *Date*

______________________________ ______________

Printed name of patient representative *Representative's authority to sign for patient (i.e., parent/guardian, power of attorney for health care, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, 4601 Heritage Trace Pkwy., Fort Worth, TX 76244.