FLORIDA E.N.T. & Allergy

Breathe Well. Hear Well. Be Well.

Comprehensive E.N.T Care for the Entire Family

A Division of ENT and Allergy Associates of Florida

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Name: _____ SS#: _____

Date of Birth: _____ / _____ / _____ Telephone #: _____

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

Name of Healthcare Facility from which Records are requested:

_____

Street: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____

Dates of Treatment Requested from: _____ To: _____

MAIL INFORMATION TO:

Florida E.N.T and Allergy
5105 N Armenia Ave.
Tampa, FL 33603

Physician: _____

Phone: (813) 879-8045 Fax: (813) 876-6504
Email: medicalrecords@floridaentandallergy.com

I hereby authorize Florida E.N.T and Allergy to obtain the health information indicated below that is contained in my patient records to the Recipient named below.

Please check all that apply:

	All Records		Operative Reports
	Patient History		Pathology Reports
	Office Notes		Radiology Reports
	Laboratory Reports		Other Specify: _____

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.** Your healthcare (or payment for care) will not be affected by whether or not you sign this authorization. Once your healthcare information is released, redisclosure of your healthcare information by the recipient may no longer be protected by law.

_____ / _____ _____ / _____ / _____

*Signature of Patient/Patient's Personal Representative ** *Printed Name* *Date Signed*

_____ _____ _____/ _____/ _____

Relationship if not Patient *Witness to Signature* *Date Signed*

** If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for healthcare). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*