Comprehensive E.N.T Care
for the Entire Family

A Division of Select Physicians Alliance

# AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Name: ______________________________________ SS#: ____________________________________

Date of Birth: ______ / ______ / _______ Telephone #: _____________________________

Address: ___________________________________ City: _______________ State: _______ Zip: _________

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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.*