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

Name: _____ SS#: _____

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

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

Clinic: _____ Physician: _____

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

Name of Recipient: _____

Street: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____

Dates of Treatment Requested from: _____ To: _____

Please check all that apply:

☐ All Records ☐ Operative Reports ☐ Patient History ☐ Pathology Notes

☐ Office Notes ☐ Radiology Reports ☐ Laboratory Reports ☐ Other Specify: _____

I specifically authorize the release of information related to:

☐ Substance abuse (including alcohol/drug abuse)

☐ Mental Health (including psychotherapy notes)

☐ HIV related information (AIDS related testing)

x_____ _____

Signature of Patient or Legal Guardian Date

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.** I understand that the recipient of my health information may be charged for the service of releasing medical information. Your healthcare (or payment for care) will not be affected by whether or not you sign this authorization. Once your healthcare information is released, re-disclosure 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.*

Return this form to

Florida E.N.T. and Allergy
6827 1st Avenue South, Suite 100
St. Petersburg, FL 33707

Therese Shumaker
Phone: 813 879 8045 ext 1903 Fax: 727 341 0332
Email: fentamedicalrecords@entaaf.com