HEAD & NECK SURGICAL ASSOCIATES

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Ear, Nose & Throat/Facial Cosmetic Surgery
Allergy Testing & Treatment
Audiology/Hearing Aids

AUTHORIZATION

FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I hereby authorize HEAD & NECK SURGICAL ASSOCIATES to release health record information on:

PATIENT_____ Date of Birth:_____

Address: _____ Social Security No: _____

_____ Telephone No: _____

TO:

_____ Telephone No: _____

_____ Fax Number: _____

Information to be disclosed:

____ Complete Record ____ Office Notes ____ Audiometrics ____ Operative Notes

____Pathology Reports ____ Lab Reports ____ X-ray Reports ____

____Other: _____

For the care given from _____ to _____

Purpose for the release of medical records:_____

I understand this information may contain information relating to Mental Health, Alcohol and/or Drug Abuse, Acquired Immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus) and is strictly confidential and disclosure is limited by State and Federal Law.

I hereby release HEAD & NECK SURGICAL ASSOCIATES from liability for the release of information made in accordance with this authorization.

I agree that a photocopy of this authorization may be considered valid.

There may be a fee for furnishing these records, and I understand that this payment is due before the records are sent.

Signature of Patient (or Guardian)	Date
Relationship to Patient	

Revised 7/11/2016