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# *AUTHORIZATION*

## *FOR DISCLOSURE OF CONFIDENTIAL INFORMATION*

**I hereby authorize TEXOMA ENT & ALLERGY and TEXOMA HEARING INSTITUTE 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 ____ 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 TEXOMA ENT & ALLERGY and TEXOMA HEARING INSTITUTE 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