TEXAS | ENT | CENTER

Texas ENT Center, LLC.

4601 Heritage Trace Parkway, Ft. Worth, TX 76244 PHONE 817-431-7985 FAX 817-431-5031

AUTHORIZATION for USE or DISCLOSURE of PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____/_____/_____

I authorize: Texas ENT Center, LLC Stephen J. White, M.D., Brandon L. Christianson, M.D._

to disclose/release all medical records* including any scans, MRIs, ultrasounds, and hearing tests to:

_____FAX # (required)_____

NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

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The information may be used/disclosed for each of the following purposes:

□ At my request (only the patient can check this box)

□ For my health care

□ For payment/insurance

□ For employment purposes

□ Other_____

_____

This authorization shall expire and may not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e.parent Guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, 4601 Heritage Trace Parkway, Keller, TX 76244.