



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the following protected health information to be released from the medical record of:

Last Name (please print) _____ First Name (please print) _____ Date of Birth _____

Social Security Number _____ Home Telephone _____ Alternate Phone _____

RELEASE RECORDS

To Austin Ent Associates To Name/Organization _____
 From 3705 Medical Pkwy, Ste. 310 From Address _____
Austin, TX 78705

City _____ State _____ ZIP _____

Phone _____ Fax _____

- Please mail my records
- Please fax my records
- Please call when my records are ready for pick-up

REASONS FOR RELEASE OF INFORMATION

- At the request of the individual
- Other (if other, describe reason for disclosure)

INFORMATION TO BE RELEASED

- Entire record
- Specific information desired _____

* I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

** I understand that this authorization is valid for six months unless I notify Austin Ent Associates otherwise. I may revoke this authorization in writing at any time except to the extent that Austin ENT Associates has already relied on this information. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand the information will be provided to me within 15 days of my requests.

Note: If mailing or faxing this form, please include a copy of your photo ID.

Signature of Patient _____ Date _____

**PLEASE FAX BACK TO
512-380-4091**