CONSENT TO RELEASE INFORMATION/TRANSFER OF RECORDS

Patient's Legal Name_____BirthDate_____

By signing this form, I am allowing **ENT Professional Services, PC** to release medical information concerning the above named patient to the person or facility listed below.

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Check the information to be disclosed:

____ Medication list _____ Allergy list _____ Immunization record ____ History and Physical____Discharge summary____ Laboratory results, _____Radiology reports _____ Consultation reports____ Test results (e.g. EKG, PFT, etc.), ____Billing Information_____ Other,specify_____

Please check the reason for release below; and provide a date by which the info is needed:

_____ Moving out of area _____ Rehab/disability _____ Insurance _____ 2nd opinion _____ Personal file _____ Legal _____ Other medical care _____ Transferring care _____

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. ENT Professional Services, PC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (initial any category not to be released). Substance Abuse_____ Mental Health _____ HIV-related information _____

*Genetic tests/info_____ *Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions. This agreement will expire two years from the date of signature, or as indicated (specify number of days or months)_____unless cancelled by the patient/guardian.

_____

Signature of Patient or Legal Guardian

_____Date_____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____

Relationship, if Not the Patient _____