AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

BURLINGTON EAR, NOSE & THROAT CLINIC, P.C.
TO REQUEST THE RELEASE OF MEDICAL INFORMATION, PLEASE COMPLETE AND SIGN THIS FORM.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

Patient Information:

Patient Name: _____ Record Number: _____

Address: _____ Date of Birth: _____

Information Requested:

_____

_____

Purpose of Release:

_____

_____

The Information is to be Provided to:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____

_____

_____ _____

Patient's Signature or Patient's Representative | Date

_____ _____

Printed Name of Patient's Representative | Relationship to Patient

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.

Under HIPAA, with a patient's written request, records must be provided within 30 days of a request.

HIPAA Authorization For Release Of Medical Records
This form does not constitute legal advice and covers federal, not state law.

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