

Frisco Family ENT Patti Huang, MD

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

Previous Name: _____ Date: _____

I request and authorize Dr. Patti Huang to release health care information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This request and authorization applies to:

_____ Healthcare information relating to the following treatment, condition, or dates:

_____ All Healthcare information

_____ Other: _____

This authorization includes the release of information about the following, if included in the medical record, AIDS/HIV-related information or testing, psychiatric disorders, drug treatment, and/or alcohol treatment. The specific dates of such records to be disclosed include: _____ I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined in HIPAA to ensure accuracy. I understand that I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing to you. Unless revoked, this authorization will expire on the following date: _____. If I choose to limit the information released, I understand that you may inform the requestor that portions of the record have been withheld. You are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

I understand that information will be provided within 15 days from receipt of request and a fee for preparing and furnishing this information may be charged to me according to the rulings set forth by the Texas State Board Of Medical Examiners.

Patient Name {Printed}

Signature of Patient or Guardian

Printed Name of Guardian

Guardian's Relationship to Patient

Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED