CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, DOB / / SSN# - -
Print Name
do hereby consent and authorize Ear Nose Throat & Audiology Associates of the Carolinas, P.A. to send my medical records to, or obtain my medical records from Dr._____ located at _____
_____

A description of the Protected Health Information (PHI) to be released:

[ ] I consent to the disclosure of **all medical records** in the possession of the provider including records, reports or test concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment, symptoms or treatment of AIDS including test results for the presence of HIV or an antibody to HIV. I understand that this serves as a dual release. (This excludes any records transferred to Ear Nose Throat & Audiology Associates of the Carolinas, P.A. from previous care providers).

[ ] I consent to the disclosure of **all medical records** with the following exceptions. *If you want to limit any records previously mentioned in any way, please indicate exactly what you do not want to release.* _____
_____
_____

[ ] I consent to the release/obtainment of the following items: _____
_____
_____

Purpose of release: _____
_____

To better serve our patients, we would appreciate knowing why you are transferring from our practice (if appropriate):

[ ] NOT TRANSFERRING [ ] MOVING [ ] CHANGE OF INSURANCE

[ ] OTHER (please specify) _____

NOTICE TO PATIENT: You may cancel this authorization in writing to the Charlotte Address listed below (Attn Office Manager) any time, except where the release of PHI has already occurred. **This authorization will expire one year from the date of consent.** There is a $15.00 administrative processing fee for each request for medical records.

_____ _____
Patient/Parent or Guardian Signature- **Date**
If there is a personal representative a description of
The representative's authority is required

Patient's Current Address: _____Phone ( ) -

NOTICE OF RECIPENT OF RECORDS: This information has been disclosed to you from records protected by the Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosures are expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by State or Federal Law.

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