ENT

PAUL BURK, DO, FOCOO
EAR NOSE THROAT MEDICAL SERVICE

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Maiden Name: _____

Relationship to patient: _____

Date of birth: _____ SSN: _____

Address: _____

Request access to requested health information below from (date) _____to (date) _____ .

○ Progress Notes	○ Patient Plan	○ Immunizations	○ Physical Form
○ Operative report	○ Radiology reports	○ Lab reports	○ Other:

Reason for request: _____

Information from	**Information to**
Name	Name
Address	Address
Phone	Phone
Fax	Fax

I understand that my medical records or the record of the patient for whom I am signing may include alcohol abuse, psychiatric records, or HIV/AIDS testing and treatment and are covered by federal regulations and cannot be disclosed without my written consent unless provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event this consent will expire on _____ or no longer than one year from the date the authorization is signed. Dr. Burk is hereby released from legal liability or responsibility for the release of records to the extent indicated and authorized herein. Dr. Burk may not condition my treatment on my provision of this authorization. A photocopy or fax of this authorization is as valid as the original.
I understand that once the information is disclosed pursuant to this authorization, the recipient may re-disclose it and the information may not be protected by federal regulations.

Signature: _____ Date: _____

Relationship to patient: _____Witness: _____

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