AUSTIN EAR CLINIC

12319 N Mopac Expy, Bldg C, Suite #300, Austin, Tx 78758-2403 Office (512) 454-0341 Fax (512) 454-9915

Authorization for Release of Medical Records

TO OUR PATIENTS: We are required by all applicable Federal and State law to maintain the privacy of your Personal Health Information (PHI).

PATIENT IDENTIFICATION	Patient _____ Date of Birth: _____ Telephone Number: _____

DESIGNATED APPOINTEE(s)

You may list a person(s) whom Austin Ear Clinic will authorize to sign and pick up your medical records as well as communicate verbally about your medical records and your treatment.

Name: _____

Telephone Number: _____

RELEASE of RECORDS TO PRIMARY CARE PHYSICIAN

It is possible for Austin Ear Clinic to send updates of significant healthcare milestones to your Primary Care Physician (PCP) as appropriate. Please indicate if you would like to release your medical records to your PCP so that they can receive your medical updates.

Would you like your PCP to receive updates from Austin Ear Clinic? **YES** ☐ **NO** ☐

Primary Care Physician (First & Last Name): _____

RELEASE OF PRINTED RECORDS

Please indicate the type of medical records you wish to have released: _____

☐ SELF- PERSONAL USE _____
Fax Number

☐ PHYSICIAN

_____
Physician's Full Name **Telephone Number**

_____
Physician's Full Address **Fax Number**

1. **I understand that Austin Ear Clinic now has permission to release and discuss my records to the person(s) stated on this form, and that I can change at any time to allow/disallow another person to receive my information if so desired, but must be restated in writing. If no one is listed above, records will be released to no one but the patient.**
2. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Austin Ear Clinic. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
3. **In addition, I understand that my medical records may contain copies of information received from other healthcare facilities and due to Federal Regulations, those records must be released from the original medical facility and not from Austin Ear Clinic.**
4. **FEES FOR PRINTED RECORD REQUESTS: The fee for record request is as follows: $25.00 for the first 20 pages and $.50 for each page after. Fees are subject to change without notice.**
5. **Records will be faxed approximately 7-10 business days after payment is received.**

_____ _____
Signature of Patient or Patient's Representative **Date of Signature**

_____ _____
Printed Name of Patient or Representative **Representative's authority to sign for Patient (Parent, Guardian, POA for Healthcare, or Executor)**