RiverENT
Adult & Pediatric Ear, Nose & Throat Specialists

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____ Phone Number: _____

I, _____, hereby authorize the designated medical records custodians or database custodians of River ENT to ☐ RELEASE or ☐ OBTAIN (Please check appropriate box) my protected health information (PHI) and copies of records pertaining to my medical care and treatment as described below:

I request my medical records:

☐ Past 3 Months ☐ Past 6 Months ☐ Past Year ☐ Entire Medical Record

☐ Radiology Reports ☐ Pathology Reports ☐ Other (Describe): _____

	Send Records To	Obtain Records From
Name	River ENT	
Address	6611 River Place Blvd., Suite 301	
	Austin, TX 78730	
Phone Number	512-677-6368	
Fax Number	512-687-1477	
Delivery Method	☐ Fax ☐ Mail ☐ Pick up by:	
Purpose of Disclosure		

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATED MENTAL HEALTH, OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.

This authorization:

- Will expire in 180 days from the date of this authorization, unless otherwise specified by me. After this date, River ENT can no longer use or disclose your PHI for the above purposes without first obtaining a new authorization form.
- May be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization, by sending such written notice to **Rick Lucas or Designee Privacy Officer, 6611 River Place Blvd., Suite 301, Austin, TX 78730** and is not effective until received by him/her.
- Is not required for obtaining treatment or reimbursement for treatment, unless the sole purpose of this authorization is to determine the payment of a claim for benefits.

I understand and agree that:

- A reasonable amount of time (not to exceed 15 days) may be required to retrieve my records.
- A fee may be charged according to Texas Medical Association guidelines. The maximum fee will be **$25 for 1-20 pages and 50 cents for each page thereafter.** The fee will be payable in advance.
- A photocopy of this release is as valid as the original.
- I am entitled to inspect and obtain a copy of my PHI maintained by River ENT.
- Per HIPAA guidelines, I have the right to request River ENT to amend my PHI or record in the designated record set.
- River ENT and its employees are released from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this agreement.
- River ENT has no control over any information and records released to any person, firm or agency under this authorization.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient's Representative (if applicable) Relationship to Patient (if applicable)