OSNT

Fax: 972-378-0656
Otolaryngology Specialists
of North Texas

Plano: 6300 W Parker Rd Ste G24
Plano, TX 75093
Phone: 972-378-0633

Dallas: 7515 Greenville Ave Ste 410
Dallas, TX 75231
Phone: 214-239-1641

Authorization for Disclosure of Confidential Information

Release of Information FROM Otolaryngology Specialists of North Texas

PATIENT NAME:_________________________________ DOB:____________________________

I hereby authorize Otolaryngology Specialists of North Texas to release the information or records specified to the person or facility listed below.

____ Phone # _________________________
____ Fax # __________________________
____

Specific information being requested:
_____Complete Medical Record. $6.50 fee for the first 20 pages. Additional pages are 15 cents per page. Please make check payable to Otolaryngology Specialists of North Texas. These fees are in compliance with the Texas State Board of Medical Examiners rules regarding fees for medical records.
_____ Partial Medical Record. You will be notified of the fee prior to the record being duplicated. Records can only be faxed in cases of medical emergency due to the patient confidentiality law.
_____ X-Rays _____Sleep Study _____CT _____ OP Report _____MRI _____Lab Report
_____ Office Notes _____Audiograms _____Other ______________________________

This information will be used for the purpose of:
______ Medical Care ______Personal Use _____Insurance______Attorney/Legal
______ Other (specify)____
This authorization covers patient care from ________________ to __________________.
I further understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- Consent will expire 180 days after the date of my signature.
- There is the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as the original.
- I may revoke this authorization, in writing, at any time by sending such written notice to Otolaryngology Specialists of North Texas, except to the extent that OSNT has already used or disclosed information in reliance on this authorization.

____________________________________ ______ ______________________________________
Signature of patient or legal representative Date

____ ______________________________________
Printed name of patient's representative Relationship to the patient