PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Date of Birth: _____ Phone Number: _____

☐ ENT and Allergy, Inc. is authorized to furnish to:

_____

_____

_____

☐ _____

is authorized to furnish to
ENT and Allergy, Inc.
3520 Post Road
Warwick, RI 02886
Fax: (401) 921 – 5826

For the Purpose of: _____

MEDICAL RECORDS (Excluding Sensitive Information):

☐ Information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease beginning _____ / _____ / _____ and, if necessary, allow them or any physician appointed by them to examine any x-rays or other diagnostic records which the facility may have regarding my condition or treatment during this period.

☐ Only those specific records as described below:

_____

_____

SENSITIVE INFORMATION:

☐ In addition, I hereby specifically consent to the disclosure and release of "sensitive medical information" concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug abuse/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

This authorization expires on _____ / _____ / _____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if minor) Date

_____ _____
Witness Signature Date