



## Medical Records Release Request Form (Use & Disclosure of Protected Health Information)

Reason Medical Record Information to Be Used or Disclosed:

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Restricted Information Covered By this Authorization: **NONE**

If **ALL** medical records are authorized for use and disclosure above, I hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are part of my medical records.

**PLEASE NOTE:** Unless otherwise restricted above, this authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information related to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-Related Syndromes. It also includes information concerning Cancer, Cancer-Testing, and Cancer results.

I agree that a copy of this release, or a fax of this release, shall be as valid as this original release. The addressee is asked to please send copies of all requested information as soon as possible to the address of the person to whom the information shall be disclosed, as listed below. I also understand that I have a right to request restrictions on this use and disclosure of certain records, those of which are also listed above.

**Medical Records Requested From:**

\_\_\_\_\_  
Clinic / Facility Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Facsimile

\_\_\_\_\_  
Contact Name

**Medical Records to be released to:**

\_\_\_\_\_  
Clinic / Facility Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Facsimile

\_\_\_\_\_  
Contact Name

**Expiration Date of Authorization**

This authorization is effective on the date signed below and only thereafter until the requested documents have been disclosed. Further disclosure of records to the same or different parties shall require a separate authorization form.

**Right to Terminate or Revoke Authorization**

You, the patient, may revoke or terminate this authorization by submitting a written revocation to Cape Fear Otolaryngology.

**Potential for Re-Disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Cape Fear Otolaryngology disclosed it to another party.

**Authorizing Signature(s)**

\_\_\_\_\_  
Name of patient (Print)

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date