Personal Health Information Release Form

Please complete this form in its entirety. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. This form will replace any that were previously submitted. Only those people listed on this form will have information released to them.

I hereby authorize: ENT Specialty Care
2004 Route 17M
Goshen NY 10924

to disclose my personal health information from my health records. I understand that this is protected health information.

First Name: _____ MI: _____ Last Name: _____
Birth Date: _____/_____/_____ SSN: _____/_____/_____ Phone: (_____) _____-_____
Street Address: _____
City: _____ State: _____ Zip Code: _____

This information is to be disclosed to (please print the name of the person/ agency you want to receive information):

Name: _____ Attention: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Office Fax Number: (_____) _____- _____ Office Phone Number: (_____) _____- _____

Dates of Treatment (if the "to" field is left blank, it is assumed to be an open-ended release):

From: _____/_____/_____ To:_____/_____/_____
Type(s) of Health Information:_____
All Records (**please check if "yes"**) _____

Affirmation of Release:

I understand that this form authorizes ENT Specialty Care to disclose my health information to the above named party. I have the right to revoke this authorization at any time by providing a written notice to the practice. I may not be able to withdraw this authorization if the practice has already taken the action initially requested by the patient or if the authorization was obtained as a means of obtaining insurance coverage. I am voluntarily signing this authorization and am not under pressure from any individual to perform this action.

Printed Name: _____
Signature (of patient or legal guardian): _____
Date of Authorization: _____/_____/_____

Where to Return Your Completed Authorization Form:
After you complete and sign the authorization form, please fax or return it to the address below:

ENT Specialty Care
2004 Route 17M
Goshen NY 10924
Fax: (845) 360-9339