OWENS EAR CENTER AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION (PHI)

___I hereby authorize the PHI of _____ (Plz print Patient's Full Name) DOB _____ to be released to: Owens Ear Center, 4104 Junius St, Dallas, TX 75246 (Fax: 214-827-0162) (Tel:1-800-686-5649)

___I hereby request Owens Ear Center disclose the PHI of _____ (Plz print Patient's Name) DOB_____

Please ___ send to or__ request from the PHI (medical records) to the address below (i.e. Your PCP)

Name: _____ Phone No.:_____ Fax # _____
Address: _____

I understand that Owens Ear Center will send the PHI Record Summary. I also understand that I must request for the complete PHI to be sent. If the complete PHI is not requested, I leave it to the discretion of Owens Ear Center to send additional PHI for continuity of care. __I am requesting the complete PHI record to be sent. Other (Specify): _____

The information is being sent for the purpose of: __Transfer to another Physician ___Specialist ___School/Day Care Requirement __Legality Purposes ___Disability Benefits ____Personal File ____ECI ___Other (Specify):_____

I understand that the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

____Yes, I consent to the release of this information
____No, I do not consent to the release of this information.

I also understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient or authorized representative is prohibited. I understand that I may inspect or copy the protected health information to be used or disclosed in CFR 164.524. I understand that I may revoke this authorization and must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal and state confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at Owens Ear Center.

Copying Fees for Medical Records: I understand a fee of twenty five dollars ($25.00) for the first twenty (20) pages and fifteen cents ($0.15) per page thereafter will be charged for all records release. In addition, a reasonable fee may be added to include actual costs for mailing, shipping or delivery. For the execution of an affidavit, an additional $15.00 will be charged. The exception to these fees will be "transferred to another physician". By law, records will be copied and mailed within 15 days from release date providing we have the appropriate permission to release information and fees. If records are needed sooner than 15 days, you will be charged accordingly.

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Owens Ear Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician or audiologist for the correct interpretation.
Signature of Patient:_____ Relationship if legal Rep:_____Date:_____
Witness _____ _____

Date request completed _____ # of pages copied _____ Reviewed only _____

Charges: $_____ Payment type _____ Cash _____ Check#_____ Initials _____

Notes_____