

Collin County Ear Nose and Throat

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of health information of:

Patient Name: _____ Date of Birth: _____

William B. Cobb, M.D.
Kenny B. Carter, Jr., M.D.

Ewen Y. Tseng, M.D.

Keith E. Matheny, M.D.
Bradford A. Bader, M.D. (Plano)

8380 Warren Pkwy
Suite 504
Frisco, TX 75034
972/596-4005
972/985-1253 (Fax)

1600 Coit Road
Suite 406
Plano, TX 75075
214/501/2021
214/501-2424 (Fax)

_____ To request records from: _____

_____ To send records to: _____

Name: _____

Address: _____

Phone: _____

Fax: _____

Please release the following:

_____ Physician Notes

_____ Blood Work

_____ X-ray Films

_____ Audiological Testing

_____ Pathology Reports

_____ Allergy Testing

_____ Imaging/Radiology Reports

_____ Operative Reports

_____ Other: _____ Treatment Dates: _____

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to this office receiving the revocation. Further details may be found in the NOTICE OF PRIVACY PRACTICE.

If the requestor or receiver is not a health plan or health plan provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

Copy fees/charges will comply with the Texas Health and Safety Code, Chapter 241, and all other laws and regulations applicable to release of information.

I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED:

Signature of Patient or Legal Representative

Date

Printed Name of Patient/Legal Representative

Relationship to Patient

Signature of Witness

Date