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: ______________

Ewen Y. Tseng, M.D. **Keith E. Matheny, M.D.**

Kenny B. Carter, Jr., M.D.	**Mark C. Littlejohn, M.D.**	**Bradford A. Bader, M.D. (Plano)**
8380 Warren Pkwy	8080 Independence Pkwy	1600 Coit Road
Suite 504	Suite 255	Suite 406
Frisco, TX 75034	Plano, TX 75025	Plano, TX 75075
972/596-4005	972/596-4005	214/501/2021
972/985-1253 (Fax)	**972/985-1253 (Fax)**	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 DISCLOUSRE 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