Shipman ENT & Associates

3201 University Dr. E Ste 375
Bryan, TX 77802
Office: 979.731.8284
Fax: 979.774.0875
www.shipmanent.com

Board certified experience. Leading edge solutions

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____DOB: _____

SSN: _____Previous Name: _____

I request and authorize **Shipman ENT & Associates** to release the medical records of the patient named above to:

Name of practice: _____

Phone: _____ Fax: _____

This request and authorization applies to:

_____All Health care information relating to the following treatment, condition or dates of treatment: _____
_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated or for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnoses, testing or treatment.

_____ _____
Signature of Patient or Patient's Authorized Representative Date Signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.).

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED