Florida Gulf Coast
EAR, NOSE & THROAT LLC

Authorization to Obtain Medical Records

Patient Name: _____ SSN: _____

Address: _____ DOB: _____

City/State/ZIP: _____ Phone: _____

I hereby request and authorize:

Practice Name: _____

Address: _____

City/State/Zip: _____

Office Telephone: _____ Fax: _____

To disclose my personal health record to Florida Gulf Coast Ear Nose & Throat:

2180 Immokalee Road,Suite101, Naples FL 34110 Phone: (239) 514-2225 Fax: (239) 514-2280	6101 Pine Ridge Road, Desk 21A Naples, FL 34119 Phone: (239) 348-4355 Fax: (239) 514-2280	9250 Corkscrew Road Naples, FL 33928 Phone: (239) 498-2528 Fax: (239) 514-2280

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure and except as otherwise provided by law such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information could include: (1) treatment for mental or emotional conditions, (2) alcohol/drug abuse, (3) HIV testing and/or test results. AN ABSTRACT OF THE MEDICAL RECORDS CONSISTS OF A DISCHARGE SUMMAR, HISTORY AND PHYSICAL, PROGRESS NOTES, OPERATIVE REPORTS, X-RAYS, LABS, AND DIAGNOSTIC STUDIES.

Information to be released/disclosed (check all that apply):

____ History & Physical
____ Progress Notes
____ Radiology Reports
____ Operative Reports
____ Laboratory Reports

____ Abstract (including, mental health information, alcohol/drug abuse, HIV testing or results)
____ Abstract (excluding, mental health information, alcohol/drug abuse, HIV testing or results)
____ Other_____

I do hereby agree to release, indemnify and hold harmless, Florida Gulf Coast Ear, Nose & Throat, its officers, directors, employees, agents and members of its medical staff from and against any claims against of liability incurred by it at any time, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent. Signing this authorization may cause the health information use or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws. This consent may be revoked at any time by notifying the Privacy Officer, except to the extent that the receiving facility has already taken action in reliance on it. This consent and authorization shall automatically expire six months from the date of the consent, unless revoked by the patient or patients authorized representative prior to the time. I further agree to pay the fee of $1.00 per page to provider the information requested. The fees are waived only if the copies are forwarded to a physician office and/or healthcare provider.

Signature of Patient: _____ Date: _____

Parent of patient or legal representative: _____ Relationship_____