# Authorization For Release of Medical Records from Chesapeake ENT, a division of CSC

Patient Name (Printed): _____ Date of birth: _____

Phone: _____ Date of request: _____

Address: _____ City/State/Zip: _____

Email: _____

The information is to be released to:

Name: _____

Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

**Choose delivery method:** ____ Pick up in office ____ Mail to address above ____ Fax to number above

____ Email to address above (records are sent via an encrypted email to ensure patient privacy)

**The information I wish to have released is (include dates of service):**

____ Exam reports ____ Surgical reports ____ Hearing tests ____ Imaging/lab reports ____ Entire record

**If Chesapeake Ear Nose & Throat is in possession of records from another provider,**

____ I do ____ I do not wish to have those records released.

**The purpose of disclosure is (only patient may check):**

____ Patient request ____ Health care ____ Payment/Insurance ____ If other, please specify_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed. 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 assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that once information covered by this authorization has been disclosed, re-disclosure of the information by that recipient is possible, and the information may no longer be protected by the federal regulations referenced above, but may be protected by Maryland law. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative Date

_____

Printed name of Patient/Parent/Guardian or Authorized Representative

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**For office use only** Date request received: _____ Date info released: _____

Person sending records: _____ Method: ____ Mail ____ Email ____ Fax ____ At front desk