AIRWAY ALLIANCE ENT
CHRISTOPHER TRAN, MD

AUTHORIZATION TO DISCLOSE/RELEASE HEALTH INFORMATION

Name of patient:_____DOB:_____

I request and authorize:

AIRWAY ALLIANCE ENT
Christopher Tran, MD & Rachael Lunney, PA-C
333 N Texas Ave, Suite 2200
Webster, TX 77598
Phone & Fax: 832-404-2601

❑ **TO DISCLOSE HEALTH INFORMATION FROM:** ❑ **TO RELEASE HEALTH INFORMATION TO:**

Name:_____

Address:_____

_____

Phone:_____ Fax:_____

Please release the information for **Continuation of care:**

Problem List:_____

❑Progress Notes

❑Medication List

❑Hearing Tests/Audiograms

❑Labs

❑X-Ray/Imaging Reports:_____

❑Other: sleep studies,_____ ❑ Entire record please

I understand that the information included may include information relating to SID's AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I will not hold Airway Alliance ENT liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the office manager.

I understand that I have legal right to revoke this authorization in writing, except for disclosures made as a condition for obtaining insurance coverage, and have been informed of how I may revoke the authorization. I understand that information used or disclosed pursuant to this authorization may be re-disclosure by the recipient and no longer protected by the medical privacy laws.

I have read and understand the consent and I have signed it of my own free will.

_____
Patient/Guardian Signature