TEXAS EAR, NOSE & THROAT SPECIALISTS, L.L.P

JAMES D. GONZALES, M.D.
PETER T. JANICKI, M.D.
TIMOTHY F. RAGSDALE, M.D.
MARY ASHMEAD, M.D.
YVONNE T. LEE, M.D.

Authorization to Release Medical Records from Texas Ear, Nose, and Throat

Patient Name: _____ DOB: ____/____/____ Date Requested: ____/____/____

Patient Address: _____ Daytime Phone: (_____) _____-_____

I hereby request and authorize:

Texas Ear, Nose, and Throat Specialists, LLP

☐ Dr. James Gonzales ☐ Dr. Peter Janicki ☐ Dr. Timothy Ragsdale ☐ Dr. Mary Ashmead ☐ Dr. Yvonne Lee

Bedford:
1615 Hospital Pkwy, Ste 210
Bedford, TX 76022
Phone: 817-540-3121
Fax: 817-355-4532

Southlake:
2813 W. Southlake Blvd, Ste 150
Southlake, TX 76092
Phone: 817-540-3121
Fax: 817-355-4508

Grapevine:
1600 W. College St, Ste 270
Grapevine, TX 76051
Phone: 817-540-3121
Fax: 817-355-4515

to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below):

_____All health information
_____Past/Present Medications
_____Physician's Orders
_____Operation Reports
_____Progress Notes
_____Diagnostic Test Reports
_____Radiology Reports & Images
_____History/Physical Exam
_____Lab Results
_____Patient Allergies
_____Consultation Reports
_____Discharge Summary
_____Billing Information
_____Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records
_____HIV/AIDS Test Results/Treatment

Please release the above noted medical records to the following physician:

Physician/Facility:_____

Address:_____

City, State, Zip: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

The reasons or purposes for this release of information are as follows:

(Choose only one option below)
_____Treatment/Continuing Medical Care
_____Personal Use
_____Billing or Claims
_____Other _____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or 1 year from the date of signature.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ _____
Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual:_____Parent of minor _____Guardian_____Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

Signature:_____ _____
Signature of Minor Individual DATE