

**Raleigh Capitol Ear, Nose & Throat**  
Anderson Drive/Cary/Brier Creek locations Fax (919) 420-2028  
Lake Boone Trail/Garner/Holly Springs/Wake Forest Fax (919) 571-8135  
Email: [medicalrecords@raleighcapitolent.com](mailto:medicalrecords@raleighcapitolent.com)

## Authorization to Release Health Information

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**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

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**Release information FROM:**

**Raleigh Capitol Ear, Nose and Throat**

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**Forward information to : Entity or person who will receive the information:**

Name: \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

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**Send the information electronically. Email address:** \_\_\_\_\_

For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

Please check what you would like included in your records.

\_\_\_ Office Notes \_\_\_ Audio Notes \_\_\_ Audio Tests \_\_\_ Speech Notes \_\_\_ Phone Notes \_\_\_ Labs \_\_\_ Radiology  
Studies \_\_\_ Pathology \_\_\_ Surgery Notes \_\_\_ Allergy Testing \_\_\_ Sleep Study \_\_\_ Referring/PCP  
Correspondence \_\_\_ FMLA\Disability \_\_\_ Billing Records

This authorization shall be in effect until the information has been forwarded as requested.

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)