Raleigh Capitol Ear, Nose & Throat
Fax (919) 571-8135
Email: medicalrecords@raleighcapitolent.com

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

Release information FROM:
Raleigh Capitol Ear, Nose and Throat

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

Name:_____

Address_____ City, State, Zip_____

Phone_____ Fax_____

☐ **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)