Medical Records Release

Patient Name: ______________________________

Date of Birth: ______________ Phone Number: ______________

Address: ______________ City: ______________ State: ______ Zip Code: ______

I hereby authorize Cross Timbers ENT

Cross Timbers ENT, PLLC
400 W. Arbrook Blvd, Ste 301
Arlington, TX 76014
Phone (817) 261-3000
Fax (817) 274-4292

To DISCLOSE/REQUEST my protected health information TO/FROM:

Physician's Name: ______________ Physician's Phone & Fax number: ______________

Physician's Address: ______________ City: ______________ State: ______ Zip Code: ______

The information that may be disclosed/requested under this Authorization includes:

☐ All Health Information ☐ History/Physical Exam ☐ Past/Present Medications ☐ Patient Allergies
☐ Physician's Orders ☐ Operative Reports ☐ Consultation Reports ☐ Pathology Reports
☐ Progress Notes ☐ Discharge Summary ☐ Lab Results ☐ Diagnostic Test Reports
☐ EKG/Cardio Reports ☐ Billing Information ☐ Radiology Reports/Images ☐ Other: ______________

***If leaving Cross Timbers ENT, please share your reason why:**

☐ Moving out of area ☐ Dissatisfied with service ☐ Insurance out of network ☐ Other: ______________

I understand that I have the right to revoke this authorization, at any time, by sending a written notification to our office.

Parent / Guardian Signature: ______________________________ Date: ______________