Advanced ENT & Allergy
Penn Medicine Ear, Nose and Throat | Affiliate

MEDICAL RECORDS RELEASE

Patient Name: _____

Address: _____

Apt. #:_____City:_____State:_____Zip:_____

Phone:_____Cell:_____DOB:_____

I authorize the use or disclosure of the above-named individual's health information as described below.

1. The type of information to be used or disclosed is as follows (check appropriate boxes).

   □ My medical records □ Other (please describe): _____

2. I understand that the information in my health record may include information relating to sexually transmitted disease,acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

3. The information identified above may be used or disclosed to the following individuals or organization(s):

   Name: _____

   Address:_____

4. The information for which I am authorizing disclosure will be used for the following purpose:
   □ My personal records □ Sharing with other health care providers as needed

   □ Other (please describe): _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. This authorization will expire (insert date or event):_____. If I fail to specify an expiration date or event, this authorization will expire 6 months from the date on which it was signed.

7. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the informationmay not be protected by federal privacy laws or regulations.

8. I understand that authorizing the disclosure of health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment of services or eligibilityfor benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

Please mail the requested information to:_____

Or fax to (NAME):_____(FAX NUMBER): _____

I understand that I may be charged a fee for copying records: $10 minimum charge, requests may take up to 30 days to process.

Signature of Patient (*or Personal Representative*):_____Date:_____

Printed Name of Personal Representative:_____Relationship to Patient: _____

After you have completed this form, please return or fax to:

Advanced ENT & Allergy – Cornerstone
103 Old Marlton Pike Suite 211
Medford, NJ 08055
Fax: 609-953-7500.