OSNT

Fax: 972-378-0656
Otolaryngology Specialists
of North Texas

Plano: 6300 W Parker Rd Ste G24
Plano, TX 75093
Phone: 972-378-0633

Dallas: 7515 Greenville Ave Ste 410
Dallas, TX 75231
Phone: 214-239-1641

Release of Information Authorization Form

Release of information FROM another doctor or healthcare facility to Otolaryngology Specialists

PATIENT NAME:_____ DOB:_____

I hereby authorize the named health care provider below to release the information or records specified TO Otolaryngology Specialists of North Texas upon request in person or by mail to the address specified.

Physician receiving records: _____Gregory N. Rohn, MD _____Fax # 972-378-0656
_____Bradford A. Gamble, MD
_____Michael E. Kubala, MD

Physician(s) sending records to Drs. Gamble, Rohn, or Kubala:
_____ Phone #_____
_____ Fax # _____

Specific information being requested: (Please indicate approx. date of information)

X-Rays_____ Sleep Study_____
CT's _____ OP Report_____
MRI's_____ Path Report_____
Office Notes_____ Audiograms_____
Other_____

This information will be used for the purpose of providing medical care.
This authorization shall be in force and effective until ___/___/_____ (MM/DD/YYYY) at which time this authorization to use or disclose this protected health information expires.

I further understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- Consent will expire 180 days after the date of my signature.
- There is the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as the original.
- I have the right to revoke this authorization, in writing, at any time by sending such written notice to Otolaryngology Specialists of North Texas, except to the extent that OSNT has already used or disclosed information in reliance on this authorization.

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed name of patient's representative Relationship to the patient