Mann Ear Nose and Throat Clinic, PA
601 Keisler Drive
Suite 200
Cary, NC 27518
Phone: 919-859-4744
Fax: 919-859-5834

For office use only		
Chart # _____		
Dr Mann	Dr Spector	Dr Jones
Release Release	Release	
Y / N	Y / N	Y / N

Authorization for Release of Health Information

LAST	FIRST	AKA
ADDRESS		
DOB:	PHONE	PHONE

I authorize:

	Mann ENT

OR

	Other facility:

To use or disclose to:

Physician:	Practice:
Address:	
Phone:	Fax:

Please check the specific documents that apply to your requests

	Sleep Studies		Allergy Tests		Audiograms (hearing tests)
	Lab Results		Radiology Results		Radiology CD
	Operative Reports		Current Visits (Office Notes)		FMLA/ Disability Forms
	Special Test		Patient Billing Records		Entire Record
	Other information to include:				

Put check next to purpose of the request

	Second Opinion		Insurance		Other:
	Attorney/Legal		Transfer of Care: Please state reason.		

Please mark how you would like your records sent

	Fax		Pick up		Mail

Please Note: Unless otherwise restricted above, this authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information related to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-Related Syndromes. It also includes information concerning Cancer, Cancer-Testing, and Cancer Results.

I understand that Mann ENT Clinic, P.A. May charge a fee for the copies of my records. I also understand that I may be required to pay the fee in full before I can obtain the copy.

I understand that I may revoke (at any time) this authorization. This authorization will expire in six months from the date signed.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization.
I understand that information 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 understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.
I understand I have the right to inspect or copy the protected health information as described in this document.

_____ _____
Signature of Patient / Guardian Date

_____ _____