SCOTCH INSTITUTE
ENT | Hearing | Allergy | Sleep
A Division of ENT and Allergy Associates of Florida

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby request and authorize: Scotch Institute of Ear Nose & Throat to release the health records specified below of:

Patient:_

Date of Birth:

- ○ All General Medical Records
- ○ Including HIV/AIDS records (if applicable)
- ○ Limited records specified below

For the purpose of:

- ○ Continuing to receive medical care
- ○ Information for the insurance company
- ○ Information for attorney
- ○ Personal use (specify)_____
- ○ Other (specify)_____

These records should be provided to:
Name of person/agency information is being disclosed to_____
Address:_____
City:_____State:_____Zip:_____
Telephone/ Fax Number:_____

Authorized by:
Signature of patient representative*_____
Date signed:_____ Relationship:_____

*If legal guardian, administrator or executor of estate, legal proof of this status must accompany this authorization. This authorization will expire _____ after the date signed.

To the recipient of the attached records prohibition on redisclosure

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the consent of the person to whom the information pertains, or as otherwise permitted by state law.