

**Annapolis Ear, Nose, Throat and Allergy Associates
2002 Medical Parkway Ste. 230 Annapolis , Maryland 21401**

SPECIFIC AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FORM 5

I authorize Annapolis Ear, Nose, Throat and Allergy Associates (Provider) to release information contained in my medical records, or to provide copies of my medical records as requested to:

Medical Information to be released: All or Specific: _____

Purpose of Authorization:

(Note: Patient may write “ for Patient’s own purposes”)

Any restrictions that I wish to impose on this authorization are listed below:

I understand the following:

1. That Provider will not refuse to provide treatment to me if I do not sign this Authorization.
2. That I may inspect or copy the information that is provided under this Authorization.
3. That if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
4. That my treatment is not conditioned upon my signing this Authorization.
5. That there is the potential that the person or entity to whom I am authorizing disclosure might further disclose the information to other persons (although they may be prohibited by law from doing so.)

This authorization is valid from today’s date, until _____, unless I revoke the authorization through written notice to Provider,

Name of Patient (Please print) Date of Birth Daytime phone number

Signature of Patient (or legally responsible individual) Date

Description of Authority of legally responsible individual