BASTIAN
VOICE INSTITUTE
for voice, swallowing & airway disorders

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I, _____, hereby authorize
(Patient Name)
Bastian Voice Institute to release to:_____the following

information contained in the patient record of _____
(Patient Name)
born_____, residing at_____.
(Date of Birth) (Address)

The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment and HIV/acquired immune deficiency syndrome (AIDS) records.

To be disclosed, the following items must be specifically checked:

- **_____ Mental Health Treatment**
- **_____ Alcohol Treatment Records**
- **_____ Drug Abuse Treatment Records**
- **_____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records**
- **_____ Laboratory Reports**
- **_____ X-Ray Reports**
- **_____ Operative Notes**
- **_____ Other_____**

The above information for the following period of time shall be released:
from_____ to_____

The purpose(s) of the authorization is (are):

_____
_____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclose4d, except as provided by law. I understand that the Bastian Voice Institute may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires unless revoked before that time. I understand that I may revoke this authorization at any time by giving written notice to the Bastian Voice Institute of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where Bastian Voice Institute has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

_____ _____
Patient/Guardian Signature **Date**