BREVARD ENT CENTER

1099 Florida Ave S
Rockledge, FL 32955
Phone: 321-632-6900
Fax: 321-639-7222

MEDICAL RECORDS RELEASE FORM

Authorization to Disclose Confidential Information

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

I hereby authorize Brevard ENT Center to disclose my confidential medical information and/or medical records as requested.

Please select one of the following options for electronic delivery of records:

[ ] **Encrypted Email**
I request that my medical records be sent through an encrypted and secure email service. I understand that additional steps, including password protection or secure access procedures, may be required to retrieve my records.

[ ] **Unencrypted Email**
I request that my medical records be sent through unencrypted email. I understand that unencrypted email is not considered a secure form of communication and may carry risks of unauthorized access during transmission. By selecting this option, I acknowledge and accept these risks and release Brevard ENT Center from liability related to unauthorized access during transmission.

Recipient Name/Facility: _____

Purpose of Disclosure: _____

I understand that I may revoke this authorization at any time by submitting written notice to Brevard ENT Center, except to the extent that action has already been taken in reliance on this authorization.

Patient Signature: _____

Date: _____

Witness/Staff Signature: _____