

EAR, NOSE & THROAT

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RECORDS RELEASE

Please fill out this form completely.
 We require at least 24 hours to complete your request.

Date needed by: _____

Today's Date: _____
 (THIS FORM WILL EXPIRE ONE YEAR FROM THE ABOVE DATE)

Name of Patient (please print full name): _____

Patient's complete address: _____

Patient's date of birth: _____

Name of person requesting records transfer: *(please print full name)* _____

Relationship to patient: _____

Phone number where you can be reached for questions: _____

The records will be SENT FROM:

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax (optional): _____

The records will be SENT TO:

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax (optional): _____

What information do you want sent? Please check the appropriate boxes.

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Dictation / Notes | <input type="checkbox"/> OP Reports | <input type="checkbox"/> Radiology / Reports |
| <input type="checkbox"/> Labs | <input type="checkbox"/> Audio | <input type="checkbox"/> Med lists |
| <input type="checkbox"/> Allergy Tests | <input type="checkbox"/> Dates: _____ | <input type="checkbox"/> Consults |
| <input type="checkbox"/> Other: _____ | | |

Information will be disclosed because of:

- Personal reasons Legal issues Transferring care
- Other: _____

My signature is approval of my authorization. I authorize the above named provider to release my protected health information to those identified on this release. I understand that if any person receives this information who is not covered by the federal privacy regulation, the release may no longer be protected. I may revoke this release at any time by a written notification unless action has previously been taken or for obtaining insurance coverage.

Signature of Patient : _____ Date: _____
 (if minor under age of 18, guardian's signature)