MIDWEST
ENT & ALLERGY
SINUS | SLEEP | HEARING | HEARING AIDS

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RECORDS RELEASE

Please fill out this form completely.

Date needed by: ____________________

Today's Date: ______________________________

(THIS FORM WILL EXPIRE ONE YEAR FROM THE ABOVE DATE)

Name of Patient (please print full name): ______________________________

Alias: ______________________________

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.

- ❑ Dictation / Notes
- ❑ OP Reports
- ❑ Radiology / Reports
- ❑ Labs
- ❑ Audio
- ❑ Med lists
- ❑ Allergy Tests
- ❑ Dates: ____________________
- ❑ Consults
- ❑ 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 Medical Practice/provider to release my protected health information to those identified on this release. I understand that if any person receives this information that is not covered by the federal privacy regulation, the release may no longer be protected.
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
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)