ENT Ear, Nose & Throat Specialty Care

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Patient Name_____ Date of Birth_____

I authorize **Ear, Nose and Throat SpecialtyCare of MN** to release/obtain my medical information.

Purpose of release:

_____ Changing Physicians _____Consultation

_____ School _____Insurance

_____ Legal/Worker's Compensation _____2nd Opinion

To:_____ From:_____

_____ _____

_____ _____

Information Authorized to release or obtain:

_____ Office notes from:_____to_____

_____ Audiograms

_____ X-Rays: CT Scans from:_____ Films/Report

MRI from:_____ Films/Report

Other from:_____ Films/Report

_____ Sleep Study Report

_____ Pathology Reports

_____ Operative Reports

_____ Lab Reports (specify)_____

_____ Other (specify)_____

This authorization will expire one year from the date signed, unless an earlier date is provided here:_____

I understand that:

- The designed record set may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, child abuse, or alcohol/drug abuse.
- This authorization for disclosure may be revoked at any time if done in writing and presented to Ear, Nose and Throat SpecialtyCare of MN.
- Revocation will not apply to information already disclosed with this authorization for disclosure and/or information disclosed for purposes of treatment, payment and health care operations.
- Refusal to sign this Authorization for Disclosure will not affect treatment..
- Authorized disclosure of information may be subject to unauthorized re-disclosure.

_____ _____

Signature of Patient/Parent or **Legal Guardian** **Date of Signature**