ENT Ear, Nose & Throat Specialty Care

Internal Use Only	Account #: ______ Completed by: ______ Date completed: ______

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request

Patient Information:	**Patient Name**: ______ **Date of Birth**: ______ Previous/Maiden Name(s): ______ Phone Number: ______
Release my records FROM:	☐ **Ear, Nose and Throat Specialty Care of MN** – *includes all ENTSC locations.* ☐ **Other** – *specify organization, department, or individual (complete below)* Name: ______ Address: ______ City: ______ State: ______ Zip Code: ______ Phone: ______ Fax: ______
Send my records TO:	☐ **Ear, Nose and Throat Specialty Care of MN** – *includes all ENTSC locations.* ☐ **Other** – *specify organization, department, or individual (complete below)* Name: ______ Address: ______ City: ______ State: ______ Zip Code: ______ Phone: ______ Fax: ______
Records to be Released:	☐ **ALL RECORDS** (or specify below) | **Specific date range: ______ to ______** ☐ Office notes ☐ Radiology Reports: ___CT ___MRI ___ Other ☐ Audiograms ☐ Operative Reports ☐ Sleep Study Report ☐ Lab/Pathology Reports (specify) ☐ Other (specify) ______
Reason for request:	☐ Continuing Care ☐ Transfer of Care/Changing Physicians ☐ School ☐ Insurance ☐ Personal Use ☐ Legal/Work Comp/Disability ☐ Other: **Date Records are Needed By:** ______
Release Method:	☐ U.S. Mail ☐ Fax: ______ ☐ Pick up by patient ☐ E-mail: ______
I understand that by signing below:	**This authorization will expire 1 year from date of signature *unless* another date is specified:** • The designated 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. • Authorized disclosure of information may be subject to unauthorized re-disclosure. • This authorization for disclosure may be revoked at any time if done in writing and presented to ENT Specialty Care of MN. This will not apply to records that have already been released. • Refusal to sign this Authorization for Disclosure will not affect treatment.
Sign and Date:	**Signature:** ______ **Date:** ______ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.

Return completed forms to:	**ENT Specialty Care - Medical Records** 6099 Wayzata Blvd. Suite 200 St. Louis Park, MN 55416	**Phone: 612-871-1144** **Fax: 612-871-2012** **Email: medicalrecords@entsc.com**

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Instructions for Completing the Authorization to Release/Receive Medical Information

Patient Information: This is the identifying information of the person whose records are to be released. This ensures that the correct patient records will be selected. *Patient's full name and date of birth are REQUIRED.*

Release my records FROM: Check only **ONE** of the boxes: check the first box if you would like your records released from an ENT Specialty Care facility/provider. Check the second box if you are requesting your records be released from a facility/provider OTHER than ENT Specialty Care. If choosing "other" please provide as much information as possible.

Send my records TO: Check only **ONE** of the boxes: check the first box if you are requesting records be sent **TO** ENT Specialty Care. Check the second box if you are requesting records be sent TO another facility/provider. If choosing "other" please provide as much information as possible.

Records to be Released: This section gives us the instructions for what information you want released. It is very helpful if you identify the date or range of dates needed by the requestor.

Reason for Request: HIPAA requires that the patient indicates why the records are being released. This also helps us track and assign a priority status to your request. If the records are needed for an upcoming appointment or specific date, please provide the date.

I understand that by signing below: Read this section carefully. This is the information you need to make an informed consent to release your records. This authorization will expire in one year unless you provide a different date (this date CANNOT be the same as the date it's signed). Services provided after the date of signature may be released according to the authorization up until it expires. To revoke the authorization, submit a written request to the address below.

Sign and Date: This form MUST be signed and dated by the patient for it to be valid. Parents/legal guardians can sign for minors as long as they state their relationship. Legal documentation showing guardianship or authorization must be on file or submitted with this form.

ENT Specialty Care of MN - Medical Records Department

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St. Louis Park, MN 55416

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Fax: 612-871-2012

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