Ear, Nose, Throat and Allergy Clinic, s.c.

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Board Certified in
Otolaryngology
Head and Neck Surgery

Image Guided Laser
Endoscopic Sinus Surgery

Snoring
Obstructive Sleep Apnea

Treatment of
Sinusitis
Chronic Facial Pain

Management of
Seasonal and Chronic
Allergic Disease

Pediatric Ear, Nose,
and Throat Problems

Head and Neck Surgery

Thyroid Disease

Otology
Audiology

AUTHORIZATION FOR RELEASE OF INFORMATION

*****EACH AREA OF THIS FORM MUST BE COMPLETED*****

AUTHORIZATION FOR RELEASE OF INFORMATION – I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.
Treatment may not be conditioned on authorization, except in the case of providing research related treatment.

I, _____ hereby release to:
(Print Name of Patient or Responsible Guardian)

_____
(Name of Healthcare Facility, Physician, Agency, or other person, to receive records – if copies are to be released to you, please write in your name or "myself")

Address Where to Send: _____

_____

Reason For Request For Release of Information: _____

Information from the Medical Record of:

_____
(Patient's Name)

_____
(Patient's Date of Birth)

_____
(Patient's Address – unless the recipient's address is the same then just indicate "same")

_____
(Patient/Guardian's Phone #)

This request will be valid until ____/_____/_____(or no more than 90 days from signature whichever comes first, or date not entered)

PATIENT'S SIGNATURE:_____ DATE: _____

SPECIFY DATES AND TYPE OF SERVICE:

_____

ONLY COMPLETE THE QUESTION BELOW IF IT APPLIES TO YOUR REQUEST

*****My request includes records containing mental health issues, HIV, alcohol and/or drug related information. Please initial here if requesting release of records containing said information. _____*****