MIDWEST
EAR, NOSE & THROAT SPECIALISTS

Date Received: _____ Initials:_____

Authorization for Release of Information

Patient Name:_____ DOB:_____ SSN_____

Address:_____ City:_____ State:_____ ZIP:_____

Daytime Phone:_____ Evening Phone:_____

☐ **I authorize Midwest ENT Specialists to REQUEST information FROM:**
Facility Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ FAX:_____

☐ **I authorize Midwest ENT Specialists to RELEASE information TO:**
Facility Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ FAX:_____

Records to be released:
Date(s) treatment was received:_____

☐Consultation report(s) ☐ History and Physical ☐Laboratory Report(s) ☐ Operative Report(s) ☐ Pathology Report(s)

☐Progress Note(s) ☐ Radiology Report(s) ☐ Radiology Film(s) ☐ Photographs, Videos or Other Images

☐Entire Record ☐ Certified Copy ☐ Itemized billing records

☐ Other _____

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained. If not indicated, information will not be released or obtained.

☐ Alcohol, Drug, Substance Abuse Records ☐ HIV/AIDS Testing/Treatment ☐ Psychiatric Evaluation/Treatment

☐ Genetic Records Dates of treatment:_____

Purpose of release: ☐Continuing care ☐Legal ☐ Personal ☐ Insurance ☐ Other:_____

Unless revoked or specified below, this authorization will expire ONE year from the date it is signed.

Event/condition/date to revoke_____

Disclosure format: (US Mail is default if not checked): ☐ US Mail ☐ E-mail ☐ Fax (only if for continuing care) ☐ CD ☐ Flash drive

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Health Information Management Department at 2080 Woodwinds Dr. Ste 120 Woodbury MN 55125.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

For Office Use Only: Account Number:_____ ID Verified □ initials:_____