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MEDICAL RECORDS REQUEST AUTHORIZATION FORM

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby authorize:

- The ENT Center
Other: \_\_\_\_\_

To (Please provide name, address, phone number and fax number):

- Receive Records From:
Send Records To:

Please choose what information you would like sent/received:

- Entire Record
Office Notes
Incoming Letters
Radiology/Lab Testing
Other
Audiology
VNG/ABR
Hospital Reports
Hearing Aid Information

Please choose the reason for the request:

- Changing Doctors
Second Opinion
Moving
Other
Consultation
Insurance Issues
Personal Records

I understand that I may review and/or copy the protected health information that is being sent or received. I understand that this authorization will be effective for one year from the date below; however, I do have the right to revoke this authorization at any time. I understand that if I choose to revoke this authorization, I must do so in writing. I understand that the information I am choosing to disclose may be re-disclosed if the recipient(s) listed on this form is not required by law to protect the privacy of the information and if the information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA), and do not hold The ENT Center responsible for the potential re-disclosure of said information.

Patient/Guardian Signature \_\_\_\_\_

Patient/Guardian Print \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_