

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

I authorize: Oakdale Ear, Nose & Throat Clinic, P.A.
3366 Oakdale Ave. N., Ste. 150
Robbinsdale, MN 55422
Phone: 763-520-7840 Fax: 763-520-2738

To release records to: Name: _____
Address: _____
Phone: _____
Fax: _____

Information disclosed for the following purposes:

- | | |
|--|--|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Attorney/Court Case/Workers' Comp |
| <input type="checkbox"/> Insurance Claim | Other: _____ |
| <input type="checkbox"/> Personal Use | _____ |
| <input type="checkbox"/> Transfer of care/Move out of area | |

Information Authorized for Disclosure: (check medical record set for entire file or check individual documents)

- | | |
|--|--|
| <input type="checkbox"/> Medical record set (includes everything listed below) | <input type="checkbox"/> Operative report |
| <input type="checkbox"/> Clinic/visit notes | <input type="checkbox"/> Pathology report |
| <input type="checkbox"/> Audiology (audiogram, tympanogram, OAE) | <input type="checkbox"/> Health history form |
| <input type="checkbox"/> Allergy (testing, annual review, injection record) | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> X-rays, CT and MRI reports (previous 2 years) | <input type="checkbox"/> Hospital discharge summary, emergency room report, admission history and physical |
| <input type="checkbox"/> Lab reports (previous 2 years) | |
| <input type="checkbox"/> Other: _____ | |

Dates of service: _____

- 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 treatment.
- This authorization for disclosure will expire in one year
- This authorization for disclosure may be revoked at anytime if done in writing and presented to Oakdale ENT
- 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.
- You may inspect or copy the information for use or disclosure with this authorization for disclosure.
- Authorized disclosure of information may be subject to unauthorized re-disclosure.

Signature of Patient / Parent or Legal Guardian

Date of signature

Relationship to patient (if non-patient signature): _____

Releasing party (staff): _____

Number of pages: _____