AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

I Authorize _____
_____
_____
_____

To Release Records to Oakdale Ear, Nose & Throat Clinic, P.A.
3366 Oakdale Ave N, Ste. 150
Robbinsdale, MN 55422
Fax # (763) 520-2738

Information disclosed for the following purposes:

_____Continuation of Care
_____Insurance Claim
_____Patient Access
_____Litigation
Other:_____
_____

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

___Medical record set (includes everything listed below)
___Discharge summary
___Emergency Department Report
___History and Physical
___Operative Report
___Lab report (previous 2 years)
___X-rays (previous 2 years)
___Consultations
___Other:_____

Dates of service: _____

- The designated record set may include information relating to sexually transmitted disease, acquired immumodeficiency 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 Patient Services
- 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): _____