ent specialists pc℠

SEND FORM TO:
ENT Specialists, P.C.
720 N. 129th St., Omaha, NE 68154
T: 402-397-0670 | Fax: 402-397-0713

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Type of Information to be Disclosed

Check applicable

☐ Office Visits, Specify (Dates _____)
☐ Imaging,Specify(Dates_____)
☐ Labs, Specify (Dates _____)
☐ All medical information in record**
☐ Other, Specify:

_____
_____

****Important Note**
Your medical record may include ***highly sensitive*** information (e.g. mental health history, history of drug or alcohol abuse, HIV, STDs, other sensitive diagnoses). By selecting this option, you agree to release this information as well.

Patient Information

I request access as the ☐ Patient ☐ Parent ☐ Guardian, Representative, or POA *(documentation required)*

Name of Patient *(print clearly)* | Date of Birth | Email

Address | City, State, Zip Code | Contact Phone Number

Manner of Information Requested: ***(charges may apply)***

☐ Mail ☐ Email ☐ Fax ☐ Pick Up at Practice

Recipient or Sender Information ***(select one side or the other)***

SEND medical information TO ☐ *(Check if same as the above)*	RECEIVE medical information FROM (Only use if sending information to ENT Specialists ☐
Name of Person or Entity *Receiving*	Name of Person or Entity *Sending*
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Telephone and Fax, if necessary	Telephone

By signing below I authorize ENT Specialists to release all medical information in the way that I have indicated on this form and certify that I have legal authority under applicable law to make this request on behalf of the patient identified above. I understand that I may revoke this authorization at any time in writing, subject to ENT Specialists's Notice of Privacy Practices. I understand that I can refuse to sign this form and still receive treatment. I understand that ENT Specialists cannot guarantee the recipient will not inappropriately re-disclose this information. I agree that this authorization will expire one (1) year after the date of signing, or after this date or event _____.

Signature of Patient or Representative | **Date** | **Name, Relationship** ***(if not the patient)***

FOR OFFICE USE ONLY

Date received: **Approved by:** **If denied, reason:**

Date records sent: