MIDWEST EAR, NOSE & THROAT SPECIALISTS | MIDWEST ALLERGY & ASTHMA | MIDWEST HEARING AID SYSTEMS | MIDWEST FACIAL PLASTIC SURGERY

2080 Woodwinds Dr. #120 Woodbury, MN 55125 • Phone 651-702-0750 • Fax 651-501-5321

Authorization for Release of Information

Patient Information

Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone#

Requesting from: (Who has the information you are requesting?)

Name of Person or Facility _____

Address _____ City _____ State _____ Zip _____

Phone#_____ Fax# _____

Sending to: (Who will be receiving the information?)

Name of Person or Facility_____

Address _____ City_____ State _____ Zip _____

Phone#_____ Fax#_____

Information to be released:

☐ Entire record
☐ Specific date(s) of service_____
☐ Radiology (☐ please check here if CD of images is needed, otherwise, a written report will be provided.)
☐ Pathology
☐ Lab work
☐ Surgeries/procedures
☐ Audio Testing
☐ Allergy Testing
☐ Billing records/statement
☐ Other _____

The purpose of the release: ☐ Continuing care ☐Second opinion ☐Transfer of care ☐Personal ☐Legal

How are the records being released? ☐ US Mail ☐ Fax ☐ Email ☐Patient pick-up

If applicable, I give permission for the following "Sensitive Protected Health Information" to be released:

☐ HIV/AIDS testing/treatment
☐ Alcohol, drug, and substance abuse records
☐ Genetic testing
☐ Psychiatric evaluation/treatment

By signing this form, I understand that:

- **This authorization is good for one year from the date signed, unless another expiration date is provided here: _____**
- **This authorization can be revoked by you at any time. Revocation must be made in writing and presented or mailed to Midwest ENT at 2080 Woodwinds Dr. #120, Woodbury, MN 55125**
- **Treatment will not be conditional upon the signing of this release**
- **Any disclosure of information carries with it the potential for unauthorized re-disclosure. Midwest ENT assumes no responsibility for any unauthorized re-disclosure of information.**

Patient name (print) _____

Patient Signature or authorized representative_____

Relationship to patient (if signed by authorized representative) _____

Date _____

For Staff Use Only

Patient Account #_____

Date Received_____ Date Completed_____

Initials Received_____ Initials Completed_____