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

215 Radio Drive, Suite 202, Woodbury, MN 55125 Phone 651-702-0750 Fax 651-501-5321 medicalrecords@mwent.net

Authorization for Release of Information

Patient Information

Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone# _____ Email _____

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

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

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
- ☐ Genetic testing
- ☐ Alcohol, drug, and substance abuse records
- ☐ 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 215 Radio Drive, Suite 202, 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_____ Initials Received_____

Date Completed_____ Initials Completed_____

Revised 6.2025