Midwest Ear Nose & Throat Consultants, Ltd.

25 N. Winfield Rd., #519	351 Delnor Dr., #310	1247 Rickert Dr., #200
Winfield, IL 60188	Geneva, IL 60174	Naperville, IL 60540
630-668-2180	630-377-8708	630-420-2323
630-681-9263 (Fax)	630-377-8774 (Fax)	630-420-8822 (Fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them. Midwest Ear, Nose & Throat Consultants, Ltd. will only include information used to make decisions about the patient. The practice may limit access to information generated only by this practice. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I _____, hereby authorize the release the following information in
(patient or authorized agent)
the patient record of _____, born _____, residing at
(patient's name – print)

_____to:

Facility / Physician / Person: _____

Street Address _____

City: _____ State: _____ Zip _____

Phone: _____

Information to be released:

- € Services from _____ thru _____
- € Allergy Records
- € X-ray, CT, MRI results
- € Other _____
- □ Specialist Chart Notes
- □ Lab Results
- □ Operative Report

I understand that my complete health records may include information regarding the following, unless the boxes below are marked your entire medical record will be released including:

- € Treatment of STDs (Sexually Transmitted Diseases) and/or HIV testing results
- € Drug or alcohol abuse
- € Psychiatric Problems

This authorization for Release of Confidential Health Information will terminate on _____.
I understand I may revoke this authorization by giving written notice to my physician.

Cost for medical records will be calculated as follows. Payment is required prior to processing:

$22.84 (administration & handling fee)
1-25 pages (above fee) + .86 cents per page
26-50 pages (above fees) + .57 cents per page
plus .29 per page in excess of 50

_____ Signature

_____ Relationship to Patient (if other than patient)

Date: _____

Physician Acknowledgement: _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT: _____

ADDRESS: _____

_____

PHONE #: _____ DATE OF BIRTH: _____

I hereby authorize that the protected health information regarding the above-mentioned person be forwarded from:

Person/Institution: _____
Address _____
City _____State_____Zip_____

Recipient: Midwest Ear, Nose & Throat Consultants, Ltd.

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Purpose or need for information: _____.

Disclosure is to include:

_____ Physician/Progress Notes	_____ X-ray/CT/MRI/US	_____ Lab reports
_____ Consultation Report	_____Pathology Report	_____ Operative Report
_____ Audiogram	_____ Allergy Results	_____ Other

Records for the period (dates) from _____to _____.

I must check one or more of the following types of health information that I do not want released to the above name Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named recipient may include any of the following:

_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse
_____ Records of HIV or STD results, diagnosis and or treatment
_____ Psychiatric, psychological records or evaluation and or treatment

I also understand that this Authorization is subject to revocation/withdrawal by me at any time to the medical record contact person at the cite of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one (1) year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Relationship to Patient

_____
Witness