EAR, NOSE, and THROAT
SPECIALISTS of WISCONSIN

AUTHORIZATION TO RELEASE HEALTH INFORMATION

For records being released by Ear, Nose & Throat Specialists of Wisconsin

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Previous/Maiden Name: _____

Phone: _____

RELEASE RECORDS FROM

Ear, Nose & Throat Specialists of Wisconsin
119 E. Bell St., Neenah, WI 54956
Phone: 920-969-1768 Fax: 920-267-5222

RELEASE RECORDS TO

Name/Facility: _____

Address: _____

Phone: _____

Fax: _____

INFORMATION TO BE RELEASED

☐ Entire medical record ☐ Office/provider notes ☐ Operative/procedure reports

☐ Audiology ☐ Allergy ☐ Imaging/diagnostic testing

☐ Lab/pathology ☐ Billing ☐ Other: _____

Dates of Service - From: _____

Through: _____

Purpose/Reason for Release: _____

AUTHORIZATION & PATIENT RIGHTS

I authorize Ear, Nose & Throat Specialists of Wisconsin to disclose the health information described above to the person or organization identified on this form. I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy law.

I understand that I may revoke this authorization at any time by submitting a written revocation to Ear, Nose & Throat Specialists of Wisconsin. Revocation will not affect information already disclosed in reliance on this authorization.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization, except where permitted by law.

This authorization expires 12 months from the date signed unless I specify an earlier expiration date or event here:
_____.

_____ _____
Patient/Authorized Representative Signature *Date*

_____ _____
Printed Name (if other than patient) *Relationship/Authority to Act for Patient*

Authorization is valid only when completed and signed. Please provide a copy to the patient upon request.