

**AUTHORIZATION TO RELEASE MEDICAL RECORDS AND/OR AUDIOGRAM**

**EAR, NOSE AND THROAT SURGICAL ASSOCIATES, S.C.**

1520 N. Meade Street, Appleton, Wisconsin 54911

Phone: 920-734-7181 \* Fax: 920-734-0621

Patient Account No. \_\_\_\_\_

I, \_\_\_\_\_  
(Name of Patient) (Maiden Name) (Birth date) (Phone Number)

authorize *Ear, Nose and Throat Surgical Associates S.C.* at 1520 N. Meade Street, Appleton, Wisconsin 54140 to disclose information from my health care record to: \_\_\_\_\_

(Name of Person or Organization)

\_\_\_\_\_  
(Address) (City) (State) (Zip Code)

I understand that the specific type of information to be disclosed includes:

- Medical Records/Reports
- Audiogram copies

for the following purpose(s): \_\_\_\_\_

This authorization for disclosure of information if effective until: \_\_\_\_\_  
(Date and/or Time)

I understand that I may revoke this authorization at any time by providing my written revocation.

\_\_\_\_\_  
(Signature of Patient or Authorized Person)

\_\_\_\_\_  
(Date of Signature)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Relationship to Patient)

NOTE: Person authorized by the patient means the parent or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survived a deceased patient, an adult member of the deceased patient's immediate family may qualify. A court appointed temporary guardian to consent to the release of records may also qualify.

Records sent on: \_\_\_\_\_ By: \_\_\_\_\_

Audiogram sent on: \_\_\_\_\_ By: \_\_\_\_\_

**DO NOT FILL THIS PORTION OUT UNTIL YOU PICK UP YOUR RECORDS.**

I understand that Ear, Nose & Throat Surgical Associates, S.C. takes no responsibility for the delivery of medical records and/or Audiogram as I have chose to hand deliver them myself.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without my authorization.