

Medical Records Use and Disclosure Release Form

Date: _____

1. I hereby authorize **MIDWEST ENT CENTRE**

To release copies of: **(Check all that apply)**

- ALL RECORDS
- Labs **
- Audiogram/ENG **
- Sleep Study **
- Operative Report **
- Pathology Report **
- CT Scan/MRI/Thyroid Ultrasound/FNA Report **
- Allergy Test Results **

2. Specific Date(s) of service: _____

3. Purpose for release of information: At my request Continuity of care Other _____

4. **Patient Name:** _____
(Last Name) (First Name) (Middle Initial) (Maiden Name)

Date of Birth: _____ **Phone:** _____

Address: _____

5. Person receiving this information:

SEND TO--NAME: _____

Address: _____

Phone: _____ Fax: _____

- I will pick up my records.
- My personal representative will pick up the records- Name: _____
(ID required for pick up)

6. This authorization will end: One time request Specific event or date: _____

Signature of patient or legal guardian: _____ **Relationship:** _____

Medical records requests can take up to 10 business days to process. Thank you.

**Fee for copying
Medical Records-** Missouri Law 191.227
\$25.34 + \$.58 per page
 You will be called with the amount due & payment is due prior to records being copied.
 Records being faxed to another doctor's office will be faxed as a courtesy.
 No charge if selected records are sent to the Follow My Health patient portal.