Ō·tō·laryn·gol'ō·gy Associates

Ear, Nose & Throat Medicine & Surgery
Head & Neck, Cosmetic & Reconstructive Facial Surgery

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient First Name: _____ **Last Name:** _____

Date of Birth: _____ **SSN:** _____

OA Physician: _____

I hereby authorize and request the release of the following information:

- ☐ **All Patient Information**
- ☐ **Patient Information for visit date(s):** _____ to _____
- ☐ **All Billing Statements**
- ☐ **Other (specify):** _____

PLEASE SEND MY RECORDS TO:

_____
Physician Name **Facility Name**

_____
Address

_____
City **State** **Zip** **Telephone**

_____
Email Address **Fax**

If intended for personal use, records over 15 pages will need to be picked up or emailed. Emailed records will be sent via encrypted message for the protection of your PHI.

Purpose of release of Information: _____

If you do not wish to release records regarding the diagnosis or treatment of HIV (aids virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment, please initial here_____. Unless initialed here this information is deemed permissible to release.

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to patient:** _____

Completed forms can be faxed to 317-819-4528, emailed to records@otolaryn.com, mailed to 9002 N. Meridian Street Suite #222 Indianapolis, IN 46260, or delivered in person at a practicing office. Faxed, emailed, or mailed requests will be completed and returned within 14 business days. Upon request, you may revoke this authorization at any time.

This authorization is valid for 60 days from date signed.

Office Use Only

OA Representative:_____ Date: _____

Printed Name:_____ In Person ____Faxed_____ Mailed _____Emailed_____