MIDWEST
EAR, NOSE & THROAT
2315 W. 57th Street • Sioux Falls, SD 57108
(605) 336-3503

RECORDS RELEASE

Please fill out form completely.
We require at least 24 hours to complete your request.

Date needed by: ____________________

Today's Date: ______________________________
(THIS FORM WILL EXPIRE ONE YEAR FROM THE ABOVE DATE)

Name of Patient (please print full name): ______________________________

Patient's address: ______________________________

Patient's date of birth: ______________________________

Name of person requesting records transfer: *(please print full name)* ______________________________

Relationship of requester to patient: ______________________________

Phone number you can be reached for questions: ______________________________

The records will be **SENT FROM:**

Physician: ______________________________ Facility: ____________________

Address: ______________________________ Phone: ____________________

City, State, Zip: ______________________________ Fax (optional): ____________________

The records will be **SENT TO:**

Physician: ______________________________ Facility: ____________________

Address: ______________________________ Phone: ____________________

City, State, Zip: ______________________________ Fax (optional): ____________________

What information do you want sent? Please check the appropriate boxes.

- ❑ Dictation / Notes
- ❑ OP Reports
- ❑ Radiology / Reports
- ❑ Labs
- ❑ Audio
- ❑ Med lists
- ❑ Allergy Info
- ❑ Dates: ____________________
- ❑ Consults
- ❑ Other: ______________________________

Information will be disclosed because of:

- ❑ Personal reasons
- ❑ Legal issues
- ❑ Transferring care
- ❑ Other: ____________________

My signature is approval of my authorization. I authorize the above named provider to release my protected health information to those identified on this release. I understand that if any person receives this information that is not covered by the federal privacy regulation, the release may no longer be protected. I may revoke this release at any time by a written notification unless action has previously been taken or for obtaining insurance coverage.

Signature of Patient : ______________________________ Date: ____________________
(if minor under age of 18, guardian's signature)