FOX VALLEY
EAR, NOSE & THROAT
ASSOCIATES

Records Request Form Instructions

- **Every** starred area must be filled in, or the records cannot be sent.

- This includes who the records are to be released to:
  – If the records are to go to the patient, please write “self” and the address where you would like the records mailed.
  – If you want to pick up the records, please write “self” and the number you would like us to call to let you know the records are ready for pick-up.

- If you have any questions, please call our office to avoid any delay in preparing the records due to an improper records request.

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Protected Health Information Release Authorization

**Patient's Full Name: _____ **Date of Birth: _____

**This will authorize Fox Valley Ear, Nose and Throat to use or disclose my protected health information to:

_____

- ☐ Complete health record
- ☐ History and physical examinations
- ☐ Consultation reports
- ☐ X-ray reports
- ☐ Audio reports
- ☐ Other (please specify) _____

**Dates of care included: _____ to _____

**The purpose of the disclosure is: _____

X I understand that I may inspect or copy the protected health information described by this authorization.

X I understand that this authorization may be revoked in writing and delivered to the offices of Fox Valley Ear, Nose, and Throat at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

X I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the Recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

X I understand that Fox Valley Ear, Nose and Throat shall not condition treatment plan on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

**Date: _____ ** Signature of patient or representative: _____

**(Authority or relationship of representative): _____