Arthur Rosner, MD
Ear, Nose & Throat Specialist
Board Certified in Otolaryngology and Sleep Medicine

- Otolaryngology
- Head & Neck Surgery
- Ear, Nose & Throat
- In-Office Balloon Sinuplasty
- Hearing Aids
- Sinus Specialist
- Pediatrics & Adults
- Sleep Apnea Surgery

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

☐ Continuing Medical Care ☐ Military ☐ Social Security/Disability
☐ Insurance ☐ Personal Use ☐ Legal Purposes
☐ School _____ ☐ Other _____

INFORMATION TO BE RELEASED OR ACCESSED:

☐ Office Visit Notes ☐ CT/MRI/PET Scan/X-ray
☐ Operative Reports ☐ All Records
☐ Lab/Path Reports ☐ Other _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses and/or treatment of drug or alcohol abuse, mental illness or communicable disease, including HIV and AIDS.

I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time (See CFR §164.508(c)(2)(i-iii).

Signature _____ Date _____
Patient or Legally Authorized Representative

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient