BURLINGTON EAR, NOSE & THROAT CLINIC, P.C.
MERCY PLAZA BUILDING
1225 South Gear Avenue, Suite 255
West Burlington, Iowa 52655

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Otolaryngology, Head & Neck Surgery

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME_____
PATIENT DATE OF BIRTH_____
PATIENT SOCIAL SECURITY NUMBER_____
PARENTS/PREVIOUS NAME(S)_____
PROVIDER RELEASING INFORMATION_____
ADDRESS_____
PROVIDER TO SEND TO_____
ADDRESS_____
INFORMATION REQUESTED: _____Complete Records _____Lab Data,Date_____
_____ EKG, DATE _____ X-ray Data, Date _____
_____Audiology Testing, Date _____
PURPOSE OF RELEASE: _____Transferring Medical Care _____Moving
_____ Insurance Coverage _____ Other

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

I specifically authorize the release of data and information relating to:

_____**1. Substance Abuse (Alcohol/Drug)**
_____**2. Mental Health (Included Psychological Testing)**
_____**3. HIV-Related Information (AIDS Related Testing)**

The authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to BURLINGTON EAR, NOSE & THROAT CLINIC, P.C.. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by BURLINGTON EAR, NOSE & THROAT CLINIC, P.C..

PROHIBITION ON REDISCLOSURE

This information does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibit further disclosure without specific written regulations. A general authorization for the release of medical or other information is not sufficient for these purposes: Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

SIGNATURE OF PATIENT OR
LEGAL REPRESENTATIVE:_____**DATE:**_____

RELATIONSHIP TO PATIENT
IF NOT SIGNED BY PATIENT:_____

WITNESS_____**DATE OF INFORMATION SENT**_____