Lawrence Otolaryngology Associates, LLC
1112 W. 6th St., Ste 216
Lawrence, KS 66044
Phone (785) 841-1107 Fax (785) 841-1173

Medical Records Release

Patient Name: _____ Date of Birth: _____ Patient Acct #: _____

Address: _____ Patient Phone #: _____

I hereby authorize:

Lawrence Otolaryngology Associates
Kansas Voice Center
1112 W. 6th Street, Ste 216
Lawrence, KS 66044
Phone: 785-841-1107 Fax: 785-841-1173

( ) Dr. Segebrecht ( ) Dr. Dinsdale ( ) Dr. Reussner
( ) Dr. Martinez ( ) Tanya Robb, APRN
( ) Jennifer Cannady, M.A., CCC-SLP
( ) Jami Johnson, M.S., CCC-A ( ) Katie Turner, AuD, CCC-A
( ) Misti Ranck, M.S., CCC-A ( ) Meryl Lockling, AuD., CCC-A

To Release To: Dr. / Clinic / Patient Name: _____

Address: _____ City, State, and Zip Code: _____
Phone number: _____ Fax number: _____

INFORMATION TO BE RELEASED:

( ) History and physical exam _____
( ) Progress notes _____
( ) Lab Reports _____
( ) X-ray reports _____
( ) Other: _____

PURPOSE OF DISCLOSURE:

( ) Changing physicians ( ) Consultation/second opinion
( ) Continuing Care ( ) Legal
( ) School ( ) Insurance
( ) Workers Compensation ( ) Self
Other _____

IF FOR ANOTHER DR. APPT **Dr. Name and Date of appointment** _____

These records are for myself. I would like these records sent to:

( ) My home address _____
( ) Please fax them to _____.
( ) I will pick them up. Please call me @ _____ when they are ready.
( ) Email them to: _____. **I understand that Internet communications are not completely confidential.**

I understand that my medical records (including any psychiatric, alcohol or drug abuse information) may be protected by Federal Regulations. I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below. I understand that my records may contain information regarding the diagnosis or treatment of HIV, (AIDS virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I understand that emailing records to me will not be secure. **Notice:** Lawrence Otolaryngology Associates, LLC has made every effort to ensure the privacy of our Internet system; however, we do not guarantee that Internet communications are completely confidential. **RESTRICTIONS: We can only copy medical records that have originated through Lawrence Otolaryngology Associates, LLC.** This authorization shall be valid for one year unless otherwise specified. Specification of the date, event or condition upon to which this consent expires (If blank this consent expires in 1 year):_____.

_____ _____
Signature of Patient, Parent, Guardian, or Authorized Rep **Date Signed**

_____
Witness Signature (REQUIRED)

I understand that a photocopy charge may be incurred for all requests except those that are directly directed to a physician or healthcare facility for continuation of care.

PROHIBITION OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALLY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM, MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAT $500, IN THE CASE OF A FIRST OFFENSE,, AND NOT MORE THAN $5000.00 IN THE CASE OF EACH SUBSEQUENT OFFESE.

Drug Abuse Officials and Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol Abuse
Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 USC 4582)

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Office Use Only:
Records have been: _____ Faxed _____ Mailed _____ Picked up by patient Date: _____ / _____ / _____

Note put into AMD _____ Yes _____ No Completed by: _____ Added to Records Request Log _____