PETOSKEY
Ear, Nose & Throat Specialists

Marc A. Feeley, MD
Melissa A. Somers, MD

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Office: 231.487.3277 Fax: 231.487.6167

RECORDS NEEDED BY: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ Birth Date:___/___/____ Phone Number: (___)___-_____
Patient Name

Dates Covered: ☐All ☐Last 2 years ☐Specific Dates: From_____to_____

Please check all that apply.
Hereby authorize the release of my medical information including (if any):

- ☐ Alcohol and drug abuse records protected under the regulation in 42 code of Federal Regulation Part II
- ☐ Psychiatric/Psychological service records and social work records
- ☐ Information regarding serious communicable diseases and infections as defined by the MDPH code (Act 368 of 1978 as revised), which includes venereal disease, TB, HIV, AIDS, or ARC.

My information may be released FROM the individual(s) or organization(s) listed below:

- ☐ Petoskey Ear, Nose, & Throat Specialists (All Providers)
- ☐ OTHER: Name: _____ Address: _____
  Phone #: _____ Fax #: _____
- ☐ OTHER: Name: _____ Address: _____
  Phone #: _____ Fax #: _____

My information may be released TO the individual(s) or organization(s) listed below:

- ☐ Petoskey Ear, Nose, & Throat Specialists (All Providers)
- ☐ OTHER: Name: _____ Address: _____
  Phone #: _____ Fax #: _____
- ☐ OTHER: Name: _____ Address: _____
  Phone #: _____ Fax #: _____

Specific type of information to be disclosed:

- ☐ All information related to my care
- ☐ Progress notes and/or History and physical
- ☐ Test results (Labs, x-ray, imaging, etc) ☐ **IMAGES ON CD**_____
- ☐ Operative Report, Pathology Report, and/or Discharge Summary
- ☐ Audiograms, Hearing Tests, and/or Hearing Aids
- ☐ OTHER: _____

The purpose and need for such disclosure is:

- ☐ Continuation of treatment or health care follow up
- ☐ Disability determination and/or Patient applying for State or Federal assistance
- ☐ OTHER: _____

This authorization is subject to written revocation at any time to the extent that Petoskey ENT Specialists has already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate in six months from date of signature.

_____	_____	____/___/___
Signature of Patient or Authorized Representative	**Signature of Witness**	**DATE**

Revised 4/3/2018