

## Medical Records Use and Disclosure Release Form

Date: \_\_\_\_\_

1. I hereby authorize **MIDWEST ENT CENTRE**

To release copies of: **(Check all that apply)**

- ALL RECORDS
- Labs \*\*
- Audiogram/ENG \*\*
- Sleep Study \*\*
- Operative Report \*\*
- Pathology Report \*\*
- CT Scan/MRI/Thyroid Ultrasound/FNA Report \*\*
- Allergy Test Results \*\*

2. Specific Date(s) of service: \_\_\_\_\_

3. Purpose for release of information:  At my request  Continuity of care  Other \_\_\_\_\_

4. **Patient Name:** \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial) (Maiden Name)

**Date of Birth:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

5. Person receiving this information:

SEND TO--NAME: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

- I will pick up my records.
- My personal representative will pick up the records- Name: \_\_\_\_\_  
(ID required for pick up)

6. This authorization will end:  One time request  Specific event or date: \_\_\_\_\_

**Signature of patient or legal guardian:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

Medical records requests can take up to 10 business days to process. Thank you.

**Fee for copying  
Medical Records**  
Missouri Law 191.227

**\$27.13 + \$.62 per page**

You will be called with the amount due & payment is due prior to records being copied.

Records being faxed to another doctor's office will be faxed as a courtesy.

No charge if selected records are sent to the Follow My Health patient portal.