CASS STREET EAR, NOSE AND THROAT ASSOCIATES, P.C.

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS
(Releases records TO Cass Street Ear, Nose, and Throat)

Patient's Name:_____

Patient's Date of Birth:_____ SS#:_____

Patient's Address:_____

_____

The Above Identified Patient is Requesting the Following Information be Obtained From:

Name of Person/Organization/Entity:_____

Address: _____ _____

Phone Number:_____ _____ Fax:_____

Information to be Released: Please Check all Applicable to Release

☐ All Medical Records to include: Medical Records, Dental Record, Immunization Record, **Mental Health Record, HIV Status, Substance Abuse.**

Dates of Service: From:_____ To:_____

☐ Other: Please Specify:_____

Purpose of Medical Record Request:
☐ Changing Doctors ☐ Moving ☐ Continuation of Care ☐ Personal Use ☐ Other_____

I understand that this Authorization is effective for a period of 90days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity / person I authorized above to release the information. If applicable, specify other expiration date / event here: _____

Signature of Patient:_____ Date:_____

Signature of Parent/Guardian:_____ Relationship:_____

Verification of Information Released

Name and Title of Person Who Released this Request:_____
How was the Request Transferred?

Sent by Mail on Date:_____ Certified?(certification #)_____

Faxed to: (number):_____ on (date):_____

Picked up by: (name):_____ on (date):_____

Verification of identification performed: Yes No