Lawrence Otolaryngology Associates, P.A.
1112 W. 6TH ST., STE 216
Lawrence, KS 66044

MEDICAL RECORDS RELEASE FORM

Patient Name: ____ Date of Birth: ____/____/____

Address: ____ Phone #:____________________

The undersigned hereby authorizes and requests:

Dr. _____________________________________ Clinic: ____

Address: _________________________________ City, State, and Zip Code: ________________________

Phone and/or fax number: ____

To Release To:

Dr. _____________________________________ Clinic: ____

Address: _________________________________ City, State, and Zip Code: ________________________

Phone and/or fax number: ____

The following information: ( ) All Records ( ) Lab Work ( ) X-Ray ( ) Other _______________________

I need these records for: (circle or check all that apply) ( )SELF

( ) INSURANCE ( )LEGAL/ATTORNEY ( ) OTHER DR. APPT

IF FOR ANOTHER DR. APPT _________________________________Other: ______________________

Dr. Name and Date of appointment

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 except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) 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."

RESTRICTIONS: We can only copy medical records that have originated through _________________.
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 1year):____.

_____________________________________ _____________________________________
Signature of Patient **(REQUIRED)** Date

_____________________________________ _____________________________________
Signature of parent, Guardian, or Authorized Rep Witness (REQUIRED)

I understand that a photo copy charge will be incurred for all requests except those directed to a physician or healthcare facility.

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 RELEWASE OF MEDICAL OR OTHER INFORMATION OF 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 FO 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)