CAPITAL REGION OTOLARYNGOLOGY

Head & Neck Group, LLP

Request for Medical Records

Patient Name: _____ Date of Birth: _____
Previous Name: _____ ID#: _____

By signing this form, I hereby authorize Capital Region Otolaryngology to disclose the health information described below to:

_____
(Name of Person or Organization)

Check all that apply:

___ All Health Information
___Health Information relating to the following treatment or condition:
_____
___Health Information for the following date(s): _____
___Other specific description: _____

Reason for this Authorization

___At my request
___Other (specify) _____
___ _____has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

This authorization expires upon _____
(Date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization, those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_____ Date: _____
Patient/Legally Authorized Representative

_____ _____
Printed Name Relationship to Patient

Note: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

(518) 482-6142 (Fax) **2001 5th Avenue**
Troy, NY 12180
(518) 274-4111
(518) 274-4110 (Fax) **963 Route 146**
Clifton Park, NY 12065
(518) 383-0065
(518) 383-2339 (Fax)