

**Paparella Ear, Head & Neck Institute, P.A.**  
**The Hearing Institute**  
 612-339-2836 or 1-866-316-0769  
 Fax 612-339-9741

**PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION**

|                        |                       |
|------------------------|-----------------------|
| <i>Patient Name:</i>   | <i>Date Of Birth:</i> |
| <i>Street Address:</i> | <i>Telephone:</i>     |
| <i>City, State:</i>    | <i>Zip Code:</i>      |

***I authorize:***

Paparella Ear, Head & Neck Institute, PA  
 701 25<sup>th</sup> Ave South #200  
 Minneapolis, MN 55454  
 (612) 339-2836 or 1-866-316-0769 phone  
 (612) 339-9741 fax

To Obtain From:     **OR**      To Release To:

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**The first 10 pages of records will be copied for our patients for free.  
 Each additional page costs \$1.15 and must be paid prior to record release.**

**Reason for Transfer:**

\_\_\_\_\_ Change of clinic                      \_\_\_\_\_ Insurance change  
 \_\_\_\_\_ Continuing care                      \_\_\_\_\_ Personal  
 \_\_\_\_\_ Other (please explain) \_\_\_\_\_

**Please transfer the following information:**

\_\_\_\_\_ All records (if all records are not required, please check the information requested)  
 \_\_\_\_\_ History                      \_\_\_\_\_ Audiogram Report  
 \_\_\_\_\_ Progress notes and summaries     \_\_\_\_\_ ECOG/ABR/ENG Reports  
 \_\_\_\_\_ X-Ray/CAT Scan Reports              \_\_\_\_\_ DPOAE Reports  
 \_\_\_\_\_ Operative Reports                      \_\_\_\_\_ Laboratory Report  
 \_\_\_\_\_ All information from \_\_\_\_\_ to \_\_\_\_\_

**Expiration Date of Authorization**

This authorization is effective through \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ unless revoked or terminated by the patient or patient's personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Minnesota Ear, Head & Neck Clinic. You should contact the Medical Records department to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

|                                     |                         |
|-------------------------------------|-------------------------|
| Patient Signature                   | Date                    |
| Signature of Patient Representative | Relationship to Patient |