PAPARELLA
EAR HEAD &
NECK INSTITUTE, P.A.

THE HEARING INSTITUTE
AT PAPARELLA EAR HEAD & NECK INSTITUTE, P.A.

Patient Authorization for Release of Information*

Patient Name:_____ Date of Birth: _____ / _____ / _____

Street Address : _____

City: _____ State: _____ Zip: _____

Phone: _____

I authorize:

Paparella Ear Head & Neck Institute, PA
701 25th Avenue South, Suite 200
Minneapolis, MN 55454
612-339-2836 or 1-866-316-0769 (Phone)
612-339-9741 (Fax)

❑ To Obtain From **OR** ❑ To Release To

_____

_____

_____

_____

Reason for Transfer:

❑ Change of clinic ❑ Continuing care ❑ Insurance change ❑ 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 ❑ ECOG/ABR/ENG reports
❑ X-ray/CAT scan reports ❑ DPOAE reports ❑ Operative reports
❑ Laboratory reports
❑ 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 Paparella Ear, Head & Neck Institute. 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: _____

*Minnesota statute retrieval and copy fees may apply.