ENT Family Clinic ~ Sinus and Snoring MD
Request for Medical Records Authorization

I, ____ or ____
Patient Name (please print) Authorized Person (please print)

Address: ____ Phone: _____________________

Request from: ____

____

____

(P)__________________________(F)_______________________

To release to: Sinus and Snoring MD, ENT Family Clinic
6127 Green Bay Road Suite 100
Kenosha, WI 53142
(P) 262-652-2887 (F) 262-764-0224

The following medical records relating to (check all that apply):
_____ Medical/Surgical Condition _____ Lab/ X-ray _____ All Medical Records

_____ Other (please specify): ____

From the medical record of _____________________________________ ___________________
Patient name (please print) Date of Birth

The above information is being released for the purpose of: (please specify)

____ continuing medical treatment _____ reimbursement purposes ____ legal purposes

____ worker's compensation claim _____ other: ____

I understand that my refusal to consent to the release of the above information will prevent the disclosure of the information. I understand that refusal of my consent would prevent the disclosure to my insurance company (if applicable) of information necessary to consider my claim. I understand that I have the right to revoke this authorization at any time by writing to my physician.

If not revoked, this authorization will expire on ___________________ (please specify) or ninety days after the date below, or sooner at my election.

I hereby release Sinus and Snoring MD / ENT Family Clinic from any and all legal responsibility or liability that may arise from the disclosure or release of the information described above, including all liability for an alleged violation of having this information maintained in confidence and privacy.

_______________________ ____
Date Signature

______________________________ ____
Relationship to Patient Witness

Office (262) 652-2887	6127 Green Bay Rd.	8870 S. Mayhew Dr.	250 W. Kensington Rd.
Fax (262) 764-0224	Suite 100	Suite 300	Suites 3B & 1A
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