Park Avenue ENT

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date of Request:_____
Patient Name: _____Date of Birth:_____
Parent or Guardian Name:_____
I authorize: _____ Jacqueline Jones, MD _____Michael Rothschild, MD to release my medical records solely to:

_____

_____

_____

This authorization is valid for 1 time only.

RECORDS REQUESTED:

- ☐ COMPLETE MEDICAL RECORD
- ☐ LABORATORY REPORT(S)
- ☐ PATHOLOGY REPORT(S)
- ☐ AUDIOLOGY REPORT(S)
- ☐ CONSULTATION REPORT(S)
- ☐ SURGICAL PROCEDURE REPORT(S)

***Please be advised that records request will take 15 business days to process, but we will do our best to expedite your request(s). Medical records will be released at your expense by Fed Ex or you can pick them up at the office. Please indicate Fed Ex or pick up.**

****The fees for medical records request & processing are:***
$15 plus postage for charts under 50 pages. Over 50 pages it will be $0.75 per page plus postage
Please include credit card information in the space provided below.

I understand that the disclosure of this health information is voluntary. I can refuse to sign this authorization. I further understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy regulations. If I have questions about disclosures of my or my child's health care, I may contact the office. I understand that I will be charged for any postage and/or handling charges to forward these records.

_____ _____
Patient or Guardian's Signature Date

Credit Card Number _____ Exp _____ CV _____

Office Use OnlyDr.'s Signature Date: _____ Date _____
# of Pages:_____ Processing Fee:_____ Postage Fee _____ Certified: Y / N Total:): Mailed/P/U: