EAR NOSE & THROAT SPECIALTIES P.C.

5055 A Street, Suite 300 Lincoln, NE 68510

Phone: (402) 488-5600 Fax: (402) 488-7649

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient name **Date of birth**

Name of doctor/practice

Address

City **State** **Zip code**

Phone # **Fax #**

I hereby request that my medical records be released to:

Ear, Nose & Throat Specialties, P.C.

Dana P. Wolfe, M.D. Christopher A. Cederberg, M.D. Kate L. Rosenberger, M.D.

Benton G. Nelson, M.D. Rebecca C. Bowen, M.D. Nichole R. Hejtmanek, D.O. Jenna C. Berg, M.D.

Ansley Alberts, PA-C Sarah R. White, PA-C Heather A. Liss, PA-C Joanna Bui, PA-C

Please release the following records to the above listed for the specific purpose of:

_____

_____

_____ _____

Date Patient/Guardian Signature

Release Expiration Date: _____ If not specified, release expires 6 months from date of release

I understand that I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.