**Lawrence Otolaryngology Associates, LLC**
**1112 W. 6th St., Ste 216**
**Lawrence, KS 66044**
**Phone - (785) 841-1107 Fax - (785) 841-1173**

# Medical Records Release

**Patient Name:** ______________________ **Date of Birth:** ___________________ **Patient Acct #:** ___________________

**Address:** ____________________________________________ **Patient Phone #:** _________________________________

**I hereby authorize:**

Lawrence Otolaryngology Associates ( ) **Dr. Segebrecht** ( ) **Dr. Dinsdale** ( ) **Dr. Reussner**
Kansas Voice Center ( ) **Dr. Martinez** ( ) **Tanya Robb, APRN**
1112 W. 6th Street, Ste 216 ( ) **Jennifer Cannady, M.A., CCC-SLP**
Lawrence, KS 66044 ( ) **Jami Johnson, M.S., CCC-A** ( ) **Katie Turner, AuD, CCC-A**
Phone: 785-841-1107 Fax: 785-841-1173 ( ) **Misti Ranck, M.S., CCC-A** ( ) **Meryl Lockling, AuD., CCC-A**

**To Release To: Dr. / Clinic / Patient Name:** ________________________________________________________________

Address: ______________________________ City, State, and Zip Code: _________________________________
Phone number: _________________________ Fax number: ___________________________________________

**INFORMATION TO BE RELEASED:**
( ) History and physical exam _______
( ) Progress notes _______
( ) Lab Reports _______
( ) X-ray reports _______
( ) Other: ________________________________

**PURPOSE OF DISCLOSURE:**
( ) Changing physicians ( ) Consultation/second opinion
( ) Continuing Care ( ) Legal
( ) School ( ) Insurance
( ) Workers Compensation ( ) Self
Other ___________________________________

***IF FOR ANOTHER DR. APPT*** **Dr. Name and Date of appointment** ____________________________________________

**These records are for myself. I would like these records sent to:**
( ) My home address ___________________________________________________________________________
( ) Please fax them to __________________________.
( ) I will pick them up. Please call me @ ___________________ when they are ready.
( ) Email them to: _______________________________________. **I understand that Internet communications are not completely confidential.**

I understand that my medical records (including any psychiatric, alcohol or drug abuse information) may be protected by Federal Regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below. "I understand that my records may contain information regarding the diagnosis or treatment of HIV, (AIDS virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released." I understand that emailing records to me will not be secure. **Notice:** Lawrence Otolaryngology Associates, LLC has made every effort to ensure the privacy of our Internet system; however, we do not guarantee that Internet communications are completely confidential. **RESTRICTIONS: We can only copy medical records that have originated through Lawrence Otolaryngology Associates, LLC.** This authorization shall be valid for one year unless otherwise specified. Specification of the date, event or condition upon to which this consent expires (If blank this consent expires in 1 year): _______________________.

_____________________________________________________ ________________________________________
**Signature of Patient, Parent, Guardian, or Authorized Rep** **Date Signed**

________________________________________
**Witness Signature (REQUIRED)**
**I understand that a photo copy charge may be incurred for all requests except those that are directly directed to a physician or healthcare facility for continuation of care.**

PROHIBITION OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALLY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM, MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEWASE OF MEDICAL OR OTHER INFORMATION OF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAT $500, IN THE CASE OF A FIRST OFFENSE,, AND NOT MORE THAN $5000.00 IN THE CASE FO EACH SUBSEQUENT OFFESE.

Drug Abuse Officials and Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol Abuse
Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 USC 4582)
**Lawrence Otolaryngology Associates, LLC**

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**Office Use Only:**
Records have been: _____ Faxed _____ Mailed _____ Picked up by patient Date: __________ / __________ / __________

Note put into AMD and Practice Fusion _______ Yes ________ No Completed by: ________