MODERN NOSE CLINIC
ALLERGY, SINUS & SNORING

Douglas J. Skarada, MD, FAAOA
Nahmjee Lee, DMD

AUTHORIZATION TO RELEASE, USE OF AND/OR DISCLOSE MEDICAL RECORDS

I authorize to ☐ RELEASE my medical information to: ☐ OBTAIN my medical information from:

_____

Name of physician, clinic, hospital, or self Phone Fax

Patient name: _____ Date of birth: _____

Purpose of records request:

☐ Continuity of care ☐ Transferring care ☐ Second opinion ☐ Referral

Other:

_____

I authorize specifically the following health information and/or medical records. Check all that apply.

☐ Clinical office chart notes
☐ Medical records needed for continuity of care
☐ Sleep Study
☐ Audiogram
☐ Diagnostic Imaging reports
☐ Other: Please list

☐ Laboratory reports
☐ Pathology reports
☐ All hospital records (incl. nurse and progress note)
☐ Emergency and Urgent care records
☐ Allergy Test

_____

_____

- I understand that, this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- I understand the this authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I specifically write on the appropriate line above. In the event the health information I request includes any of these types of information, I specifically authorize release of such information to the person or entity indicated herein.

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- I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above maybe re-disclosed and no longer protected by these regulations.

Signature of patient or patient's legal representative | Date

Print Patient name of legal representative | Relationship to patient

MNC Medical Record Release Rv 7/2017