OTOLOGIC CENTER
EAR CARE EXCELLENCE

Authorization For Use Or Disclosure Of Medical Information

Patient Name _____ Date of Birth _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

1.) Release the following information:

☐ Visit History Other: _____

☐ Radiology Reports Other: _____

☐ Audiograms Other: _____

☐ Test Results

2.) Information to be RELEASED BY/TO:

Organization: _____ Telephone: _____

Attention: _____ Fax: _____

Street Address _____ City _____ State _____ Zip _____

3.) Information to be RELEASED TO/BY:

☐ Bradley S. Thedinger, M.D.
☐ Robert D. Cullen, M.D., FACS
☐ Joseph A. Ursick, M.D., FACS

Otologic Center Inc
3100 Broadway Street, Suite 509, Kansas City, MO 64111
Phone: 816-531-7373 Fax: 816-531-1404

I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Medical Records department of Otologic Center Inc., or to the other organization named. Unless this authorization is revoked, it will expire once the disclosure is complete.

I understand that authorizing the disclosure of this information is voluntary. I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have any questions about disclosure of my information, I may contact the Practice Administrator of Otologic Center Inc., at (816) 531-7373.

Signature of Patient, Parent or Legal Guardian _____ Date _____

Relationship to Patient _____