EAR NOSE & THROAT CLINIC

Otolaryngology - Head & Neck Surgery
Richard P. Raugust, M.D.
Thomas H. Hammond, M.D.
Sam Kim, M.D.

Phone: (907) 456-7768
Fax: (907) 456-4045

Fairbanks Hearing and Balance Center
1919 Lathrop Street, Suite 104
Fairbanks Alaska 99701

MEDICAL RECORDS RELEASE

Patients Name: _____ Birthdate: _____
Phone Number: _____
Address: _____ Apt. Number: _____
City: _____ State/Zip: _____

Records Request From:
Name: _____ Phone Number: _____
Company Name: _____ Fax Number: _____
Address: _____ Suite Number: _____
City: _____ State/Zip: _____

Send Records To:
Name: _____ Phone Number: _____
Company Name: _____ Fax Number: _____
Address: _____ Suite Number: _____
City: _____ State/Zip: _____

How would you like to obtain these records? Please check one.

- ☐ Mail
- ☐ Fax
- ☐ Pick-up (with photo identification)

Please allow us 7 - 10 business days to copy your medical records
Tell us what medical records you would like sent.

- ☐ Complete Medical Records
- ☐ Lab or Pathological Reports
- ☐ Audiometric Studies
- ☐ Medications
- ☐ Other: _____
- ☐ X-Ray Reports
- ☐ Operative Notes
- ☐ Chart Notes
- ☐ Allergy Records

Authorization for Release of Medical Data

This authorization will expire 1 year from signature date below.

Signature: _____ Date: _____
Relationship: _____

FOR OFFICE USE ONLY

Staff Signature: _____ Date: _____
Print Name: _____

EAR NOSE & THROAT CLINIC

Otolaryngology - Head & Neck Surgery
Richard P. Raugust, M.D.
Thomas H. Hammond, M.D.
Sam Kim, M.D.

Phone: (907) 456-7768
Fax: (907) 456-4045

Fairbanks Hearing and Balance Center
1919 Lathrop Street, Suite 104
Fairbanks Alaska 99701

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in my treatment, directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as physician certifications and quality assessments.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given a copy of the *Notice of Privacy Practices* prior to signing this consent. I understand that this organizations has the right to change its policy from time to time and that I may contact you to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed and that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Signature: _____

Relationship: _____

FOR OFFICE USE ONLY

HIPAA Policy Form

REFUSED Date: Initials: _____