DAVID R. HANTKE, M.D., INC.

David R. Hantke, M.D., F.A.C.S.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Dr. Hantke/_____ to use of disclose the specific information described below, only for the purposes and to the parties also described below.

Description of the specific information to be used or disclosed:

- ❑ General medical records
- ❑ Operative reports
- ❑ Lab results
- ❑ Audiometric results
- ❑ Other: _____

Person or entity requesting the information and authorized to make the requested use or disclosure:

_____

Authorized recipient of the information:

- ❑ Dr. Hantke
- ❑ Other: _____

The information is being requested for the following purpose(s):

_____

_____

This authorization shall remain in effect from the date signed below until:

_____
(please allow enough time for us to actually release the records)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting this office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA regulations.
- I may refuse to sign this authorization and you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

❑ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____