OTOLOGIC CENTER, INC.
3100 Broadway Street, Suite 509, Kansas City, MO 64111
Phone: (816) 531-7373 Fax: (816) 531-1404
www.otologiccenter.com

OTOLOGY & NEUROTOLOGY
Bradley S. Thedinger, M.D. Robert D. Cullen, M.D., F.A.C.S.**Joseph A. Ursick, M.D., F.A.C.S.**

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:** (PLEASE CIRCLE)
Organization: _____Telephone:_____
Attention: _____ Fax: _____
_____
Street Address City State Zip

3.) Information to be **RELEASED TO/BY:** (PLEASE CIRCLE)
- ❑ Bradley S. Thedinger, MD Otologic Center Inc
- ❑ Robert D. Cullen, MD, FACS 3100 Broadway Street, Suite 509, KC MO 64111
- ❑ Joseph A. Ursick, MD, FACS 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 Incorporated 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