Diseases of the Ears, Nose and Throat, Inc.

Otologic Surgery ● Head and Neck Surgery ● Endoscopic Sinus Surgery ● Pediatric Surgery

Complete Audiologic Services ● Dizziness

Otolaryngologists
Timothy J. Nash, DO
Timothy P. Drankwalter, DO

Audiologists
Melinda L. Heater, AuD
Audra H. Woods, AuD

MEDICAL RECORD DISCLOSURE

Authorization for disclosure of medical record information to Diseases of the Ears, Nose and Throat, Inc.

Patient Information

Patient Name _____ D.O.B._____

Guardian name (if minor) _____

Address _____

Phone _____

The undersigned herby authorizes and requests from:

Name _____

Address _____

Phone _____ Fax _____

To provide to:

Diseases of the Ears, Nose and Throat, Inc.
600 Taylor Station Road
Gahanna, OH 43230
Ph: (614) 759-8811 Fax: (614) 759-8812

Access to medical records for the purpose of review and examination and further authorizes and requests that you provide such copies as may be requested.

_____1. Covering records from period _____ to _____.

_____2. Confined to the following specific information:

_____

_____

_____3. No limitation placed on dates, history or illness or diagnostic or therapeutic information.

_____ _____

Signature (relationship or authority to authorize disclosure) **Date**

_____ _____

Witness **Date**

**Per Ohio Revised Code, there *may* be charges associated with processing, copying and mailing/faxing of medical records. Notification of charges will be provided, and payment will be expected prior to processing.