**Karen E. Boone, M.D.**

**Robert R. MacDonald III, M.D.  
J. Matthew Conoyer, M.D., F.A.C.S.  
Benjamin M. Conoyer, M.D.  
Matthew P. Page, M.D.**

**Medical Records Use and Disclosure Release Form**

Fee for copying

Medical Records

Missouri Law 191.227

$29.47 + $.68 per page

You will be called with the amount due & payment is due prior to records being copied.

Records being faxed to another doctor’s office will be faxed as a courtesy.

No charge if selected records are sent to the Follow My Health patient portal.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I hereby authorize **MIDWEST ENT CENTRE**

To release copies of: **(Check all that apply)**

( ) ALL RECORDS

( ) Labs \*\*

( ) Audiogram/ENG \*\*

( ) Sleep Study \*\*

( ) Operative Report \*\*

( ) Pathology Report \*\*

( ) CT Scan/MRI/Thyroid Ultrasound/FNA Report \*\*

( ) Allergy Test Results \*\*

1. Specific Date(s) of service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Purpose for release of information: 🞏 At my request 🞏 Continuity of care 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last Name) (First Name) (Middle Initial) (Maiden Name)

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:**

**Address:**

1. Person receiving this information:

🞏 SEND TO--NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

🞏 I will pick up my records.

🞏 My personal representative will pick up the records- Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ID required for pick up)

1. This authorization will end: 🞏 One time request 🞏 Specific event or date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient or legal guardian**: **Relationship:**

Medical records requests can take up to 10 business days to process. Thank you.