OPL Otolaryngology Physicians Of Lancaster
Board Certified Ear, Nose and Throat Specialists

Lancaster Office:
810 Plaza Boulevard
Lancaster PA, 17601
Office 717-394-5088
Fax 717-394-5590

Ephrata Office:
177 North Reading Road
Ephrata PA, 17522
Office 717-733-4891

MEDICAL RECORDS REQUEST AUTHORIZATION FORM

Patient Name ______________________________

Date of Birth ______________________________

I hereby authorize:

☐ Otolaryngology Physicians of Lancaster ☐ Other: ______________________________

To (Please provide name, address, phone number and fax number):

☐ Receive Records From: ______________________________

☐ Send Records To: ______________________________

Please choose what information you would like sent/received:

☐ Entire Record
☐ Office Notes
☐ Incoming Letters
☐ Radiology/Lab Testing
☐ Other ____________
☐ Audiology
☐ VNG/ABR
☐ Hospital Reports
☐ Hearing Aid Information

Please choose the reason for the request:

☐ Changing Doctors
☐ Second Opinion
☐ Moving
☐ Other ____________
☐ Consultation
☐ Insurance Issues
☐ Personal Records

I understand that I may review and/or copy the protected health information that is being sent or received. I understand that this authorization will be effective for one year from the date below; however, I do have the right to revoke this authorization at any time. I understand that if I choose to revoke this authorization, I must do so in writing. I understand that the information I am choosing to disclose may be re-disclosed if the recipient(s) listed on this form is not required by law to protect the privacy of the information and if the information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA), and do not hold Otolaryngology Physicians of Lancaster responsible for the potential re-disclosure of said information.

Patient/Guardian Signature ______________________________

Patient/Guardian Print ______________________________

Relationship to Patient ______________________________

Date ______________________________