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.

Practice Administrator: Teresa K. Calais

Audiology
SANDRA A. BROWN, M.A., CCC-A
SHAWN N. MCCLURE, Au.D., CCC-A
AMY NUNNELEE, Au.D., CCC-A

Nurse Coordinators
ROYS THEDINGER, R.N.
ELENA FOSTER, L.P.N.
KATE LEVINE, R.N.
MARIA OLSON, R.N.

MEDICAL INFORMATION RELEASE CONSENT

The Otologic Center has adopted a policy that requires our staff to obtain written authorization from the patient to share your medical information with **ANYONE** other than you (the patient). This policy is to protect your rights to privacy. However, we also acknowledge that you (the patient) may want to share your medical information with a family member and/or close friend.

Please fill out the form below if you would like to authorize individuals to have access to your private health information. Any changes to add or eliminate **ANY** individual from this consent **MUST** be submitted to our office in writing **IMMEDIATELY**. Please note it is **OPTIONAL** to release information to other individuals, but form must be signed regardless.

Please list names of individuals you wish to **GRANT ACCESS TO YOUR MEDICAL INFORMATION.** (Release **MUST** be signed and dated.)

NAME: _____Relationship:_____

NAME: _____Relationship:_____

NAME: _____Relationship:_____

I give my consent to my doctor and/or staff of Otologic Center, Inc. to share my private health information with the individuals I (the patient) have chosen above.

Please sign and date form below regardless of choosing to release information to other individuals or not.

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____

DATE:_____

RECEIPT OF PRIVACY POLICY

I, _____, have received a copy of the Notice of Privacy Practices for Otologic Center, Inc.

_____ _____
Signature of Patient or Parent/Guardian Date