Ō·tō·laryn·golō·gy Associates
ENT & Face, Head & Neck Plastic Surgery
www.otolaryn.com

EFFECTIVE 06.01.2026, A CHARGE WILL APPLY TO PATIENT RECORD REQUESTS!!

If a patient is requesting records for themselves only, there will now be a charge.

- *The patient must complete a Release of Information (ROI) form before any request can be processed.*
- *We will not know the total charge upfront. The Medical Records Department must first review the completed ROI and requested documentation.*
- *Once the review is complete, Annette or Dawn will contact the patient directly with the total cost and confirm if they would like to proceed.*
- Our office charges patients a fee to obtain a copy of any PHI for personal use. The fees are as follows (see attached invoice for complete details):
    - Retrieval Fee (first 10 pgs included) $20
    - Copy Fee (pages 11-50) $0.50 per page
    - Copy Fee (pages 51+) $0.25 per page
    - Rush Order (within 2 business days) $10.00
    - Certification of Medical Records Fee $20 (form must be submitted with the record request-we DO NOT supply)

YOUR MEDICAL RECORD REQUEST WILL BE PROCESSED WITHIN 5 BUSINESS DAYS AFTER PAYMENT HAS BEEN RECEIVED. ****PLEASE ENCLOSE OF COPY OF THIS PAGE ALONG WITH ANY OTHER REQUIRED FORMS WITH YOUR CORRESPONDANCE (COMPLETED AUTHORIZATION FORM, INVOICE, ETC), THANK YOU!**

Office Contact Information: Medical Records Dept, ask for Dawn Webster x1345 or Annette Lewis x4039 or email dwebster@otolaryn.com & alewis@otolaryn.com, Thanks!

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION (ROI)

Patient Information: Patient Full Name: _____
Date of Birth: _____ SSN (last 4 digits only): _____ Account #: _____

Treating Provider(s) *(Select one or more, as applicable)*

☐ Dr. Michael Agostino	☐ Dr. Valerie Ball	☐ Dr. Jeffrey Beach	☐ Dr. Richard Biggerstaff
☐ Dr. Seth Bruggers	☐ Dr. Benjamin Copeland	☐ Dr. Heidi Dunniway	☐ Dr. Swapna Eisinger
☐ Dr. Thomas Fairchild	☐ Dr. Anthony Fama	☐ Dr. David Fang	☐ Dr. John Goldenberg
☐ Dr. Jason Gutt	☐ Dr. Scott Hackett	☐ Dr. Lauren Hansen	☐ Dr. Nicole Klein
☐ Dr. Eric Knoll	☐ Dr. Clement McDonald III	☐ Dr. Thomas McSoley	☐ Dr. James Miner
☐ Dr. Michael Myers	☐ Dr. Maximillian Newell	☐ Dr. Ruchin Patel	☐ Dr. Laryn Peterson
☐ Sarah Polacek, PA-C	☐ Brittany Spaulding, PA-C	☐ Dr. Megan Wood	☐ Dr. Robert Youkilis

Other Divisions (if applicable): ☐ Whisper Hearing Centers ☐ Balance Point

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Records Requested: ☐ All records on file ☐ Records for specific date(s) of service: _____
☐ Other (please specify): _____

Records Requested From: *(Name, organization, phone, fax, and/or email)*

Records to Be Released To: *(Name, organization, phone, fax, and/or email)* **Please note:** Effective January 1, 2026, records will **not** be mailed.

Purpose of Disclosure: _____

If records are requested for **personal use**, they may be sent by fax or encrypted email. Email delivery will be provided via **encrypted PDF format**. **Please allow up to fourteen (14) business days to complete this request.**

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Authorization: I authorize Otolaryngology Associates, NS ENT, and their affiliated divisions to release the protected health information described on the front of this form to the individual(s) or entity(ies) listed for the stated purpose. **I understand that an electronic signature is as valid as an original signature.**

Sensitive Information (Optional Restriction): If you **DO NOT** authorize the release of information related to **HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, mental health conditions, or psychiatric treatment**, please initial here: _____. If no initials are provided, this information will be released as permitted by law.

Electronic Transmission: I understand that electronic transmission of health information may involve certain risks. By requesting records via email, I authorize delivery by encrypted electronic means and accept responsibility for receipt once transmitted.

Revocation of Authorization: I understand that I may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken in reliance on this authorization.

Expiration: This authorization is valid for **six (6) months** from the date signed below unless revoked earlier.

Signature: Patient Signature: _____ Date: _____
Printed Name: _____ Relationship to Patient: _____

Submission Instructions: Completed forms may be submitted by: **Fax:** 317-573-4352 or 317-819-4536

Email: records@otolaryn.com **Mail:** Otolaryngology Associates 10201 N. Illinois Street, Suite 110 Carmel, IN 46290

Security Notice: The most secure methods for transmitting this information are in person, mail, or fax. Patients who choose to transmit this authorization or protected health information via email acknowledge and accept the associated risks of electronic transmission.

For Office Use Only: Method Records Released: ____Faxed ____Emailed ____Mailed (if apply)
OA Personnel Signature/Name: _____Date: _____