

Ear, Nose & Throat Associates, MD, PA

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Re: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Print Patient's Name
SSN: \_\_\_\_\_

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any re-disclosure is strictly prohibited without the written permission of the patient/legal representative identified below.

I authorize: \_\_\_\_\_
Name of Facility/Person Holding the Information
\_\_\_\_\_
Address
\_\_\_\_\_
City, State, and Zip Code
\_\_\_\_\_
Fax

To Release my medical records the following: (please initial next to each applicable area)

- \_\_\_ General medical information
\_\_\_ Audiology test results
\_\_\_ Surgical Records

To: \_\_\_\_\_
Name of the Facility/Person to Receive the Information
\_\_\_\_\_
Address
\_\_\_\_\_
City, State, and Zip Code
\_\_\_\_\_
Fax

For the purpose of: \_\_\_\_\_

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing). I also understand that this authorization will remain in effect for (90) days unless I specify an earlier expiration date here: \_\_\_\_\_ (date).

Patient/Legal Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_
Legal Representative's Relationship to the Patient \_\_\_\_\_ Signature of Witness \_\_\_\_\_
Print Name of Person Requesting Records \_\_\_\_\_ Phone Number of Person Requesting Records \_\_\_\_\_