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