



Board Certified Otolaryngology
Head & Neck Surgery

Authorization to Release Medical Information / Records
PLEASE PRINT CLEARLY

Patient name _____
Last First Initial

Date of Birth _____ Social Security # _____ Phone # _____

Release records FROM :

Address _____
Releasing Doctor _____
Street _____
City Zip Phone _____

Release records TO:

Address _____
Recipient Doctor _____
Street _____
City Zip Phone _____

Release records Via: *MINIMUM OF 1-2 DAYS FROM DATE OF REQUEST*

MAIL TO (Name / Address): _____

FAX TO (Name / Fax #): _____

PICK UP (Phone number to call when records are ready for pick up): _____

_____ I consent to release information regarding **Substance Abuse**
(initials)

_____ I consent to release information regarding **Mental Health**
(initials)

_____ I consent to release information regarding **HIV / AIDS**
(initials)

I understand that I may revoke this consent any time prior to the actual sending of the medical information.

Patient or Legal Representative Signature Date