Ear
Nose
&
Throat
CENTER

Otolaryngology
Head & Neck Surgery

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Authorization to Release Medical Records

Patient name (printed) ___________________________________

Date of Birth _____________

Phone number, if we need additional information or have any questions _____________________

Please release all of my medical records (including progress notes, operative reports, audio/hearing reports, laboratory, CT or MRI results, etc.) to:

Choose ONE of the following two options.

( ) Send records to my home address listed below:

____

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( ) Send records to the doctor of my choice:

Dr. _______________________________________

Address ____________________________________

____

Phone # ___________________________________

This authorization expires ______________________

X _________________________________ Date ____________
Signature of patient/guardian

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