Authorization to Release Information

Date: ______________________

Patient Name: ________________________________ Former Name: __________________________________

DOB: ________________________ SSN: _______________________ Patient ID: ________________________

Date of Last Visit: _______________ Date of Surgery: _______________ Physician: ___________________

I, ________________________________, authorize ENT, Ltd., to obtain/release the following information regarding my medical care from/to the persons listed below:

_____ History and Physical
_____ Operative Report
_____ Test Results
_____ Discharge Summary
_____ Treatment Summary
_____ Consultation Report
_____ Radiology Report
_____ Laboratory Report
_____ EKG Report Date
_____ Other: ____

Name: ____________________________________ Relationship: _________________________________

Name: ____________________________________ Relationship: _________________________________

Name: ____________________________________ Relationship: _________________________________

____ ________________________

Signature Date

I understand that I may withdraw this consent at any time.

WITHDRAWAL:

I withdraw consent for _____________________ effective _______________________.

____ ________________________

Signature Date