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 release the following information regarding my medical care to the persons listed below:

_____ History and Physical
_____ Operative Report
_____ Test Results
_____ Discharge Summary
_____ Treatment Summary
_____ Consultation Reports
_____ 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