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 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

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