THE CENTERS FOR ADVANCED ENT CARE

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Home Phone: _____ **Daytime Phone:**_____

Address:_____

Please note: copy fee may be charged for medical records.

I request and authorize *The Centers for Advanced ENT Care* to release healthcare information of the above-named patient to:

Name:_____

Address:_____

Phone:_____**Fax:**_____

Email (if applicable): _____

This request and authorization applies to the following treatment, condition, or dates:

_____

_____

___Please mail records **___Will pick up records**

___Please email records **___Please FAX records**

X_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative **Date**

X_____ _____
Printed Name of Representative **Relationship/Capacity to Patient** **Witness Signature** **Date**

This authorization is valid for one year after date signed

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