ENT CONSULTANTS

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AUTHORIZATION FOR RELEASE OF INFORMATION MEDICAL AND BILLING

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

Previous Name: _____

I hereby authorize _____ to release my medical/billing

information to: _____

Copies of my medical records, including any information regarding medical, psychiatric, alcohol, drug testing or treatment, AIDS, AIDS-related complex (ARC), HIV infection or billing summaries related to any such conditions, are requested and authorized to be released.

This release of records applies to: _____

Covering records for the period of: _____

I understand that I have the right to revoke this consent at any time unless information has already been released in reliance upon my previous consent. Submitting a written notice of revocation to the releasing party may revoke my consent. I understand this authorization is only valid for the date of signature and prior; no future dates or records will be released.

I hereby release _____, its employees, staff, and agents from any liability which may arise as a consequence of the disclosure of the information set forth above relating to my medical/billing records.

Signature: _____ Date: _____
Patient or Guardian

Witness: _____ Date: _____

Any subsequent disclosure of medical/billing information by the recipients is prohibited without the express written consent/authorization from the above-names patient/guardian.