

Authorization for Disclosure of Confidential Information

RELEASE OF INFORMATION TO SOUTHWEST ENT ASSOCIATES

Patient Name _____

Address _____

Date of Birth _____ Social Security # _____

I authorize:

Name of person/facility _____

Address _____

To release medical information to SouthWest ENT Associates:

Check all that may be released:

History/Physical Progress Notes Care Plan
 Lab/Reports EKG Report OP Report
 Other (Please Specify) _____

This authorization covers patient care given from

_____ to _____

Purpose of disclosure:

Medical Care Attorney Insurance
 Other (please specify) _____

This authorization shall be valid for 120 days from the date of signature.
The patient can revoke this authorization in writing at any time prior to the expiration date.

The patient agrees that a photocopy of this authorization may be considered valid:

Yes No

Patient Signature _____ Date _____

If patient is a minor, relationship to the patient: _____