NEVADA ENT

MEDICAL RECORDS REQUEST AND AUTHORIZATION

Name of Patient: _____

Date of Birth:_____

I authorize release of my records from Nevada ENT & Hearing Associates to the party (ies) listed below. I understand that the specific types of information to be released are only those records generated by this office and/or ordered by the above physician(s). Your request will be processed and fulfilled within 30 working days.

_____

NAME

_____(___)_____

ADDRESS **FAX**

_____

CITY, STATE, ZIP

_____

NAME

_____(___)_____

ADDRESS **FAX**

_____

CITY, STATE, ZIP

Please include the following:

(_) Physician notes

(_) Radiology, Lab and/or Pathology Reports

(_) Operative Reports

(_) Billing Information

(_) Other:_____

This authorization for disclosre of information is effective for (1) year from the date signed and can be revoked at any time by written notification.

_____

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT **DATE**

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