



Head and Neck
S U R G E R Y
A S S O C I A T E S , P S C

*Pediatric and Adult Diseases of
the Ear, Nose and Throat*

Allergy

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE the complete history records in your possession concerning my illness and/or treatment. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions during the period:

Dates From _____ **To** _____

Patient Name: _____
(please print)

Patient Date of Birth: _____

Address: _____

Date of Release: _____

Signature: _____

Witness: _____

Note: If the person signing the release is not the patient, the relationship of the person signing must be stated and verifiable.

Relationship: _____

Verified by: _____

TO BE MAILED TO:

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