



**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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