COLLIER OTOLARYNGOLOGY
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Fax: (239) 592-1835

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME: _____

ADDRESS: _____

TELEPHONE: _____ DATE OF BIRTH: _____

I the undersigned, authorize the release of medical records to:

( ) Myself: _____

( ) Physician: _____

Address: _____

( ) Other authorized person (s): _____
(Relationship and legal authority to do so)

PLEASE SPECIFY THE INFORMATION REQUESTED:

The following information: _____

Purpose of Disclosure: _____

_____

Signature: _____
(If signed by other than the patient, state legal authority to do so)

Date: _____ Expiration: _____