Brian A. Metz, M.D., FACS David K. Hill, M.D., FACS
Guerin M. Smith, M.D.
Phone: 913.764.2737
Fax: 913.764.7502

Records Release Authorization

Name of Patient: _____ Date of Birth: _____

I hereby authorize you:
Name: _____

Phone: _____ Fax: _____

Address: _____
_____

Release Medical Records to:

Midwest Ear, Nose & Throat, LLC
20375 W. 151st Street. Suite106
Olathe, Kansas 66061
Office: (913) 764-2737
Fax: (913) 764-7502

The following medical information pertaining to my medical care:

_____ Partial medical records (please specify parts to be released or dates of service to be released):
_____ Complete Medical Records

The above information is to include information pertaining to:

_____ Alcohol or substance abuse or treatment
_____ AIDS or HIV antibody treatment
_____ Psychiatric/ mental heath diagnosis or treatment

Or, the above information is NOT to include information pertaining to:

_____ Alcohol or substance abuse or treatment
_____ AIDS or HIV antibody treatment
_____ Psychiatric/ mental heath diagnosis or treatment

X_____ X_____
Patient or Legal Guardian Signature **Date**

X_____ X_____
Witness Signature **Date**

(This authorization is valid until six months from the date originally signed)

p/allclincforms/scheduling/06/11