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RECORDS RELEASE AUTHORIZATION

Name of Patient: _____ Date of Birth:_____

Obtaining Records From: **Midwest Ear, Nose & Throat, LLC**
20375 W. 151St, Suite 106
Olathe, KS 66061

I hereby authorize you to release to:

Name: _____

Phone: _____ Fax:_____ Email: _____

Address: _____

_____

The following medical information pertaining to my medical care:

_____ Partial medical record (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 health diagnosis or treatment

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

_____ Alcohol or substance above or treatment
_____ AIDS or HIV antibody treatment
_____ Psychiatric/mental health diagnosis or treatment

Signature of **Patient** or **Legal Guardian** _____

Date _____ **Witness** signature _____
(This authorization is valid until six months from the date originally signed.)