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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 health 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 health diagnosis or treatment

X _____
Patient or Legal Guardian Signature

X _____
Date

X _____
Witness Signature

X _____
Date

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