

# RECORDS RELEASE AUTHORIZATION

I, \_\_\_\_\_ (Date of Birth) \_\_\_\_\_ hereby authorize BergerHenry  
Print Name  
ENT Specialty Group to release to \_\_\_\_\_ the following:

- Audiogram
- Complete Medical Records
- Test Results
- Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Concerning my illness and/or treatment in the period from \_\_\_\_\_ to \_\_\_\_\_  
for the purpose of \_\_\_\_\_  
\_\_\_\_\_

Please release to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
FAX # \_\_\_\_\_

Signature \_\_\_\_\_ Date\* \_\_\_\_\_

If other than patient, state your relationship \_\_\_\_\_

Patient Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Phone No. \_\_\_\_\_

This authorization is valid for \_\_\_\_\_ days from today\*.

**NOTICE:** Patient has the right to revoke this authorization at any time. Once this information is released to above named person/practice, it may no longer be protected by federal privacy law.