RECORDS RELEASE AUTHORIZATION

I, _____ (Date of Birth) _____ hereby authorize Berger/Henry
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.