SOUTHWEST EAR, NOSE & THROAT
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1760 McCulloch Blvd., N., Suite 100
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (please print)

Name: _____ DOB: ____/_____/_____

SSN# _____

I hereby authorize ***SOUTHWEST EAR, NOSE & THROAT*** to send copies of my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

Please send these records to:

_____

_____

_____

PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING.

_____ **Date: _____/_____/_____**
Signature of Patient (or Parent of minor child)

_____ **Date: _____/_____/_____**
Witness

SENT DATE: _____/_____/_____ INITIALS: _____