

Patient Name _____ *Birthdate* _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FOR REVIEW AND TO AID IN THE TREATMENT OF MY SYMPTOMS. THIS DOCUMENT ALLOWS GREENBRIER VALLEY ENT, PLLC TO DISPENSE AND/OR REQUEST MEDICAL, PRESCRIPTION INFORMATION, ETC. CONCERNING MY CONDITION TO THE PARTY/PARTIES DESIGNATED BELOW. THIS INFORMATION IS INTENDED FOR THE SOLE USE OF MY TREATMENT AND IS NOT TO BE DISTRIBUTED TO ANY OTHER ENTITY THAN THE DESIGNATED PARTY.

INFO REQUESTED FROM _____ FAX _____

INFO RELEASED TO _____ FAX _____

****THIS PRACTICE REQUESTS ALL PATHOLOGY, FILMS, AND/OR RECORDS RELATING TO THE TREATMENT OF THE ABOVE MENTIONED PATIENT.***

PATIENT SIGNATURE

DATE