Ear, Nose & Throat Center
655-A Kenmoor Ave SE
Grand Rapids, MI 49546-2375
Phone: 616-575-1212
Fax: 616-575-1219

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Print

PATIENT INFORMATION	Name:_____ Date of Birth:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____
CLINIC OR HOSPITAL (Who has the information that you would like released?)	☐ **Ear, Nose & Throat Center** (Check if appropriate) **OR** Name:_____ Address;_____ City:_____ State:_____ Zip:_____ Phone: ( )_____ Fax: ( ) _____
PLEASE SEND INFORMATION TO:	☐ **Ear, Nose & Throat Center** **Fax: 616-575-1219** **655-A Kenmoor Ave SE, Grand Rapids, MI 49546-2375** **OR** Name:_____ Address:_____ City:_____ State:_____ Zip:_____ Phone: ( ) _____ Fax: ( )_____
INFORMATION TO BE DISCLOSED (Only the information checked will be released)	__ All Records __ History and Physical __ Pathology Reports __ Consultation Reports __ Laboratory Reports __ Specific Dates of Service From:_____ To:_____ __ Radiology Reports (X-ray, CT, MRI, etc) __ Progress Notes __ OTHER: _____ _____ _____
SPECIAL DISCLOSURES	__ Chemical Dependency __ Psychiatric __ HIV __ Specific Dates From:_____ To:_____; concerning the Specific Diagnosis of:_____.
REASON FOR DISCLOSURE	__ Continuing Care __ Personal Use __ Insurance __ Legal __ Other: _____
REVOCATION	I understand that I may revoke this consent at any time unless the facility which is to make the disclosure of information has already done so in reliance upon my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to the facility releasing this information. If not revoked, this authorization is valid until it expires 6 months from the date signed below or until the following date, event, or condition.
AUTHORIZATION SIGNATURE	**I authorize the above provider to release the information marked to the requesting party.** _____ **Patient / Guardian Signature** **Date** _____ Relationship to Patient Reason Patient is Unable to Sign