ENT Family Clinic ~ Sinus and Snoring MD
Release of Medical Records Authorization

I, _____ or _____
Patient Name (please print) Authorized Person (please print)

Address: _____ Phone: _____

Hereby authorize: Sinus and Snoring MD, ENT Family Clinic

To release to: _____
_____
_____
(P)_____(F)_____

The following medical records relating to (check all that apply):
_____ Medical/Surgical Condition _____ Lab/ X-ray _____ All Medical Records

_____ Other (please specify): _____

From the medical record of _____ _____
Patient name (please print) Date of Birth

**The above information is being released for the purpose of: (please specify) continuing medical treatment, reimbursement purposes, legal purposes, worker's compensation claim, etc., …

_____

I understand that my refusal to consent to the release of the above information will prevent the disclosure of the information. I understand that refusal of my consent would prevent the disclosure to my insurance company (if applicable) of information necessary to consider my claim. I understand that I have the right to revoke this authorization at any time by writing to my physician.

If not revoked, this authorization will expire on _____ (please specify) or ninety days after the date below, or sooner at my election.

I hereby release Sinus and Snoring MD, ENT Family Clinic from any and all legal responsibility or liability that may arise from the disclosure or release of the information described above, including all liability for an alleged violation of having this information maintained in confidence and privacy.

_____ _____
Date Signature

_____ _____
Relationship to Patient Witness

Office (262) 652-2887
Fax (262) 764-0224
sinusandsnoringmd.com

6127 Green Bay Rd.
Suite 100
Kenosha, WI 53142

8870 S. Mayhew Dr.
Suite 300
Oak Creek, WI 53154

250 W. Kensington Rd.
Suites 3B & 1A
Mount Prospect, IL 60056