



**MEDICAL RECORD RELEASE AUTHORIZATION**

**Patient Name (Print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Facility, Doctor, Organization or agency which the Medical Records are needed from:

**I am the** (Check off which applies)  PATIENT  GUARDIAN  OTHER \_\_\_\_\_ and hereby authorize:

*COLDEN EAR NOSE THROAT AND ALLERGY  
1 Wallace Bashaw Jr Way, Suite 3002  
Newburyport, MA 01950  
Phone #: (978)-997-1550 \*Fax #: (978)-499-8200*

**DISCLOSE/SEND RECORDS TO** or  **REQUEST/RECEIVE RECORDS FROM**

Medical information from the Name of the Doctor, Organization, Agency, or Person listed Below:

NAME:  
ADDRESS:  
PHONE #:  
FAX #:

**Records to release** (i.e. Visit Notes, X-RAY/CT/MRI reports, test results etc.): \_\_\_\_\_

**Dates of Service to release:** \_\_\_\_\_

**The purpose for this request to release medical information is:**

Medical Care / Treatment  Insurance  Other (specify) \_\_\_\_\_

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the express purpose identified above, unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Notice: Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care names of all health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease (STD's), including AIDS information.

Exclusions (Please initial:): Drug/Alcohol\_\_\_\_, Mental Health/Psychiatric\_\_\_\_, STD's\_\_\_\_ HIV/AIDS\_\_\_\_, Hepatitis\_\_\_\_

This authorization is valid for one year or until \_\_\_\_\_, whichever comes first.

**PATIENT SIGNATURE: X** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Guardian/Other (If applicable) X** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when it's purpose has been accomplished. (There may be a processing fee to release medical records).

*A photocopy of this release is as valid as the original. Updated 09/2024.*