COLDEN SEYMOUR
EAR NOSE THROAT & ALLERGY
Adult & Pediatric Care / Hearing & Balance Center
Sinus & Sleep Specialists / Facial Plastic Surgery

Daryl Colden, MD FACS Peter Seymour, MD FACS

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 & SEYMOUR 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: _____

A photocopy of this release is as valid as the original. *Updated 10/2019*
I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished. (There will be a processing fee to release medical records)