Arizona Ear, Nose and Throat Physicians, PLLC

14510 West Shumway Dr., Suite 101
Sun City West, Arizona 85375

10503 West Thunderbird Blvd., Suite 104
Sun City, Arizona 85351

RELEASE OF MEDICAL RECORDS
AUTHORIZATION FORM

Type of Records Requested to Be Forwarded:

- [ ] Complete chart
- [ ] Laboratory reports
- [ ] Surgical report
- [ ] Special testing _____

I hereby authorize and request that my records be released to:

_____

_____

_____

_____

Patient's Name: _____

Patient's Date of Birth: _____

Street Address: _____

City, State, Zip _____

_____ _____

Patient's Signature Date of Signature

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. This authorization shall be in force and in effect for ninety (90) days after the signed date above at which time this authorization to use or disclose this protected health information expires. I have given my consent freely and voluntarily. I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Arizona Ear, Nose, and Throat Physicians PLLC at 14510 West Shumway Drive., Suite 101, Sun City West, Arizona 85375. I understand that a photocopy / facsimile of this authorization is considered acceptable in lieu of the original.