Southeast Michigan
Ear, Nose, and Throat

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Ear, Nose, & Throat • Sinus & Allergy • Head & Neck Surgery

Medical Records Release

Name: _____ Phone: _____ Date of Birth: _____

From: _____ To: _____

_____ _____

Phone: _____Fax: _____ Phone: _____ Fax: _____

Method of Delivery: ☐ **Fax** ☐ **Mail** ☐ **Pick Up**

1.) Please check the appropriate:

___Any/All of my medical records, as of the date of this release.

___Any/All of my medical records, except the following: _____

___Only the following from my medical records: _____

2.) Please check below if you **DO NOT** want the following to be released. This information will be released unless the appropriate box is selected:

___Any record of treatment for drug and/or alcohol dependency or abuse

___Any record of mental health treatment

___Any record of testing, treatment, or reporting pertaining to infection with HIV or related diseases

___Other: _____

3.) These records are being released for the following reason:

___Continuation of Care

___Transferring to a new doctor in the area

___Changing insurance. If so, please list insurance plan: _____

___Transferring to a new doctor due to dissatisfaction with:

___Waiting time in office ___Patient Care ___Other (please specify) _____

I authorize the release of medical records except the above noted records:

Signature (Parent/Guardian): _____Date: _____

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