



Southeast Michigan Ear, Nose, and Throat

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Medical Records Release

Name of Patient: _____ Date of Birth: _____ Phone: _____

From: _____ To: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Method of Delivery: FAX MAIL PATIENT PICK-UP

1) Please check the following you want released:

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

____ Any/All 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 option is selected below:

____ 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 reasons:

____ 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 noted above. The records checked under option two (if noted) will not be released.

Signature (parent/guardian): _____ Date: _____

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