BECKER
EAR, NOSE & THROAT CENTER

# AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Becker ENT to transfer, release, or obtain information on the following:

(Name of Patient) (Date of Birth) (Social Security Number)

(Patient Address) (Telephone Number)

(City, State, Zip)

OBTAIN FROM:

(Institution/Physician)

(Attention)

(Address)

(City, State, Zip)

(Phone) (Fax)

SEND OR FAX TO:

(Institution/Physician)

(Attention)

(Address)

(City, State, Zip)

(Phone) (Fax)

## PLEASE CHECK SPECIFIC INFORMATION REQUESTED

___ ALL RECORDS
___ LABORATORY
___ X-RAY REPORT
___ CT REPORT
___ MRI REPORT
___ PROGRESS NOTES
___ OPERATIVE NOTES
___ AUDIOGRAM
___ ALLERGY TESTING
___ SLEEP STUDY/CPAP

_____ OTHER (PLEASE SPECIFY)

(SIGNATURE OF PATIENT OR PARENT/LEGAL REPRESENTATIVE

(RELATIONSHIP TO PATIENT) (DATE)