Authorization to Release Patient Information

Patient Name:_____ Date of Birth: _____

I hereby consent to the disclosure of the specific information listed below, as it concerns the above named patient of Pediatric Otolaryngology Head & Neck Surgery Associates, P.A.

I am authorizing: Pediatric Otolaryngology Head & Neck Surgery Associates, P.A.
PO Box 76479
St Petersburg, FL 33734

Telephone: 727.329.5400 Fax: 727.329.5401 or Toll Free 866.229.1589

To release the medical records contained in the above named patient's medical record:

Date(s) of Treatment: From: _____ To: _____
Re: The Diagnosis of: _____
Other: _____

Please forward these records (as specified above) to:

Name of Outside Facility/Physician: _____

Mailing Address:

_____

Address City State Zip

Telephone #: _____ Fax #: _____

Please forward these records by the following method of communication:
____ US Postal Mail
____ I will pick up at the _____ Office (Must arrange with staff member)

_____ _____
Signature of Legal Representative Date of Signature

(This signature is valid for one (1) year from the above "Date of Signature.")

_____ _____
Relationship to Patient Phone number where you may be reached

PLEASE NOTE:
Only test results, the office visit notes and/or surgery notes of the physicians/physician extenders of Pediatric Otolaryngology Head & Neck Surgery Associates, PA will be copied and forwarded for this request unless otherwise noted.

21JUNE17