Authorization to Receive 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:

Name of Outside Facility/Physician: _____

Mailing Address: _____
Address City State Zip

Telephone #: _____ Fax #: _____

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:

Pediatric Otolaryngology Head & Neck Surgery Associates, P.A.
PO Box 76479
St. Petersburg, FL 33734
Telephone: (727) 329-5400
Fax: (727) 329-5401

Please forward these records by the following method of communication:
____ US Postal Mail
____ Fax: 727-329-5401

_____ _____
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