SOUTH VALLEY
EAR NOSE & THROAT

South Valley Ear, Nose & Throat

Release of Information

Patient Name _____

Date of Birth _____ Phone Number _____

Address _____

Authorization is given to

South Valley Ear, Nose & Throat

To receive and release information to:

Dr. / Medical Facility _____

Address _____

Phone _____ Fax _____

Please check below:

- ☐ Office Notes
- ☐ Audiology Reports
- ☐ Surgery Reports
- ☐ CT Scans
- ☐ Labs/Pathology Reports
- ☐ Ultrasound Reports
- ☐ Transferring Care
- ☐ Last 5 Years
- ☐ Records Concerning:
- ☐ Records from Date of Service:
- ☐ Other:

I understand that my consent is given and may be revoked at any time. I also understand that all information will be kept confidential and will be used for professional purposes only. This release expires one year from the date signed below.

_____ _____

Patient/Guardian Signature Date