



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:

<input type="checkbox"/> Office Notes	<input type="checkbox"/> Transferring Care
<input type="checkbox"/> Audiology Reports	<input type="checkbox"/> Last 5 Years
<input type="checkbox"/> Surgery Reports	<input type="checkbox"/> Records Concerning:
<input type="checkbox"/> CT Scans	<input type="checkbox"/> Records from Date of Service:
<input type="checkbox"/> Labs/Pathology Reports	<input type="checkbox"/> Other:
<input type="checkbox"/> Ultrasound Reports	

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

www.southvalleyent.com

West Jordan

3584 W. 9000 S., Suite 311
West Jordan, UT 84088
(801) 566-8304

Murray

5169 S. Cottonwood St., Suite 310
Murray, UT 84107
(801) 507-3444

Riverton

4651 W. 13400 S., Suite 120
Riverton, UT 84096
(801) 562-9350