MILE HIGH
OTOLARYNGOLOGY

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RECORD RELEASE

Name: _____ Date of Birth: _____

Phone: _____ SS#: _____

Release to: _____

_____

_____

_____

Release from: _____

_____

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_____

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s).

1. Drug abuse/Alcohol abuse (Federal Regulation 42 C.F.R., Part 2)
2. Psychological or Psychiatric conditions.
3. A test for the presence of antibodies (HIV)/virus that causes AIDS.
4. An AIDS diagnosis and/or an AIDS related condition.
5. Any third party source (e.g., Hospital, Specialist, Laboratory).

INFORMATION REQUIRED *(Please select all items you authorize to be released):*

☐ Doctors Notes ☐ X-Ray Reports ☐ Path Reports ☐ Drug/Alchohol Abuse ☐ History & Physical ☐ Lab Reports

☐ Third Party Record ☐ Diagnostic Stud ☐ AIDS/HIV info ☐ Psych Evals ☐ Other

Treatment Dates: _____ Purpose of Release: _____

_____ _____

Signature of Patient Date

_____ _____

Witness Signature of Legal Guardian/Executor

Fax: (303) 487-6932