Metro ENT & Facial Plastic Surgery
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Phone: (301)315-0003 Fax: (301)315-0002

Authorization for Release of Medical Information

Patient's Last Name: _____ First Name _____ M._____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

DOB: _____ Home Telephone: _____ Alternate Telephone: _____

Date Requested: _____ Date Needed: _____

PLEASE OBTAIN INFORMATION FROM:	OR	PLEASE SEND INFORMATION TO:
_____ Name of Provider/Facility		_____ Name of Provider/Facility
_____ Street Address		_____ Street Address
_____ City, State, Zip Code		_____ City, State, Zip Code
Phone: _____ Fax: _____		Phone: _____ Fax: _____

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.) ☐ Physician's office notes ☐ MRI/CAT Scan ☐ Lab Test

☐ Operative Report ☐ Sleep Study ☐ Entire Record ☐ Billing Record ☐ Other _____

Date(s) of service if known: _____

Restrictions and/or Exclusions (if any): _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of information will not be released without a valid signature below.
- There may be a charge for the requested records.

_____ Signature of Patient (if 18 years of age or older)

_____ Date

_____ Signature of Parent or Guardian (if minor patient)

_____ Relationship to Patient

☐ Fee Explained ☐ ID Needed

Distribution: Original to medical record. Copy to requester, as required.

☐ Pick-Up Records ☐ Mail Records ☐ Fax Records

Preparer's Signature: _____