THE CENTERS FOR ADVANCED
ENT CARE
METRO ENT & FACIAL PLASTIC SURGERY

15001 SHADY GROVE RD STE 100
ROCKVILLE, MD 20850-6354
PHONE (301) 315-0003 FAX (301) 315-0002
SCOTT F. DALY, M.D.
ANNETTE M. PHAM, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip code:** _____

DOB: _____ **Home Tel:** _____ **Alternate No.:** _____

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 ❒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 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: _____