

Permission to Release Medical Records

Patient Name _____ Date of Birth _____

Permission is hereby granted for release of information from:

- | | |
|---|---|
| <input type="checkbox"/> Patrick Radecki, M.D. | <input type="checkbox"/> Andrew K. Patel, M.D. |
| <input type="checkbox"/> Craig K. Hertler, M.D. | <input type="checkbox"/> Dustin Bronsdon, Au.D. |
| <input type="checkbox"/> Maxwell C. Furr, M.D. | <input type="checkbox"/> Christina Quang, Au.D. |

To provider (if self, write "self") _____

Address (or fax number) _____

The following information may be released:

- | | | |
|--|--|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Abstract of medical summary | <input type="checkbox"/> X-Ray reports / X-Ray films |
| <input type="checkbox"/> Hospital summary | <input type="checkbox"/> Chart notes | <input type="checkbox"/> CT reports / CT films |
| <input type="checkbox"/> Electrocardiogram | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Audiogram |
| <input type="checkbox"/> Laboratory data | <input type="checkbox"/> NCV | <input type="checkbox"/> Sleep study report |

For the following date(s) of service (if all, write "all") _____

I consent to transmission of my medical records via facsimile (fax) machine.

Signature _____ Date _____

I recognize that the information disclosed may contain mental health, drug, or alcohol information that is protected by federal and state law. I specifically consent to release of such information.

Signature _____ Date _____

I recognize that the information disclosed may contain information regarding sexually transmitted disease of HIV/AIDS tests. I specifically consent to disclosure of such information.

Signature _____ Date _____