PDX ENT & AUDIOLOGY MEDICAL GROUP

Permission to Release Medical Records

Patient Name _____ Date of Birth _____

Permission is hereby granted for release of information from:

☐ Patrick Radecki, M.D.
☐ Andrew K. Patel, M.D.
☐ Craig K. Hertler, M.D.
☐ Dustin Bronsdon, Au.D.
☐ Maxwell C. Furr, M.D.
☐ Chris Lawson, Au.D.

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

Address (or fax number) _____

The following information may be released:

☐ All records
☐ Abstract of medical summary
☐ X-Ray reports / X-Ray films
☐ Hospital summary
☐ Chart notes
☐ CT reports / CT films
☐ Electrocardiogram
☐ Immunizations
☐ Audiogram
☐ Laboratory data
☐ NCV
☐ 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 _____