T E N T

T U C S O N
EAR, NOSE & THROAT

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM TUCSON ENT ASSOCIATES, PC

PATIENT INFORMATION (PLEASE PRINT):

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____

RELEASE MY MEDICAL RECORDS FROM:
TUCSON ENT ASSOCIATES, PC
2121 N Craycroft, Building 5
TUCSON, AZ 85712
ATTENTION: Medical Records
(520) 296-8500, EXT 1135
FAX NUMBER: (520) 495-7508

TO:
PATIENT/LEGAL GUARDIAN OR PHYSICIAN
(Please circle only one)

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Fax:_____ Phone:_____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic test results.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient or Legal Guardian:_____Date:_____

The PHI contained in this letter is HIGHLY CONFIDENTIAL.
Any other use is a violation of HIPAA and will be reported as such.