TENT
TUCSON
EAR, NOSE & THROAT

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

Date:_____

To:_____
(Physician name/group)

Address:_____

City:_____ State:_____ Zip Code:_____

Fax number:_____

Regarding:
Patient's Name:_____

Date of Birth:_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO DOCTOR:_____
(Please print name)

Please send to the following address or fax number:

TUCSON ENT ASSOCIATES, PC
ATTENTION: MEDICAL RECORDS
2121 N Craycroft, Building 5
TUCSON, AZ 85712
Fax Number: (520) 495-7508 Phone Number: (520) 296-8500, ext 1135

Patient's or Authorized Signature:_____

Please include:_____

_____

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