AUTHORIZATION TO RELEASE INFORMATION

I herby authorize Dr. Bruce Klenoff, Dr. Jason Klenoff, Dr. Biana Lanson, and/or Dr. Jacquelyn Brewer to release medical records and incidental information that may be necessary for medical care, processing insurance claims and applying for insurance benefits. Furthermore, I release the Ear, Nose and Throat Center from all legal responsibility or liability that may arise from this authorization.

Name of Patient: ____________________________________________________________

Relationship: Self ______ Parent ______ Guardian ______ POA ______ State Liaison ______

Please briefly describe exactly which records you would like released (example: office notes, x-rays, blood work):

Signed: ____________________________________________________________________

Witness (office use only): ______________________________________________________

Date: ______________________________________________________________________