****Outgoing****

100 Tessitore Ct. Suite B | Montrose, CO 81401
970-787-4710
970-615-7007 FAX

PATIENT IDENTIFICATION:

_____
Name

_____
Last 4 digits SS#

_____
Birth Date

RELEASE TO:

_____
Name

_____
Address

_____
City/State/Zip

GENERAL AUTHORIZATION: I hereby request and authorize Colorado West Otolaryngologists, P.C. to release my medical records to the above named. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed. I release Colorado West Otolaryngologists, P.C, my physician and all CWO personnel from any and all liability concerning disclosure of this information.

SPECIFIC AUTHORIZATION: ( ) Please initial. Specifically authorize the release of the following information.

- ❑ Alcohol and/or Drug Abuse, if any
- ❑ HIV/AIDS Status, if any
- ❑ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

- ❑ Copies of hospital History & Physical, Discharge Summary, Operative Reports
- ❑ Copies of imaging studies
- ❑ Copies of office visits
- ❑ Copies of audiograms
- ❑ Copy of complete chart
- ❑ Verbal medical/billing information
- ❑ Other
  (specify): _____

This authorization ends: □ on _____(no longer than 1 year from date signed)
□ When the following event occurs_____

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

_____
Signature of Patient or Parent/Legally Authorized Person

_____
Date

_____
Printed name of person authorized to sign for patient

_____
How authorized

Records released by: _____ Date: _____
Records □ picked up □ mailed □ faxed