Delaware Otolaryngology Consultants LLC
17316 Coastal Hwy Suite 1 Lewes DE 19958
Office 302-644-2232 Fax 302-644-2237

Authorization for Release of Records

I _____ _____/_____/_____
(patient name) (DOB)

Authorize the below:

_____
(Dr or Practice)
_____
_____
_____
(Address, Phone # and Fax #)

To Release my Protected Health Records to;

Dr Beth Duncan MD

(O)302-644-2232 (F) 302-644-2237
17316 Coastal Hwy Suite 1
Lewes DE 19958

I authorize the release of all information and I am aware that the records released may contain information relating to psychiatric or psychological testing, sexually transmitted diseases AIDS,HIV,physical abuse, or drug and alcohol abuse. Initials:_____

⬐ Most Recent Office Note **⬐ Complete Medical Record** **⬐ Imaging / Labs**

⬐ Other:_____

By Fax or Mail

Signature of patient, parent, guardian, conservator or patient representative. (please circle one)

_____ _____/_____/_____
Signature **Date**

_____ _____/_____/_____
Witness **Date**