DESOTO
ear • nose • throat

7164 Hacks Cross Rd, Suite 105/106
Olive Branch, MS 38654
o 662.895.6455
f 662.895.6460

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name_____

Social Security Number:_____DOB:_____

Release Records From:

_____

_____

_____

_____

Send Records To:
DeSoto Ear, Nose, and Throat

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Olive Branch, MS 38654
662-895-6455, fax: 662-895-6460

Healthcare Coverage Period from:_____to:_____

Health Records requested:

( ) Progress Notes
( ) Lab
( ) Radiology Reports
( ) Other_____

I understand that specific information to be released may include AIDS or HIV, Alcohol, and/or Drug Abuse and Mental Health issues. I accept responsibility for the release of these documents and information contained herein. Unless otherwise indicated, this authorization will expire one year from the date of this signature. DeSoto Ear, Nose, and Throat and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization for the purposes stated above. I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____
Signature Relationship Date