

Alamance Ear, Nose & Throat and Facial Plastic Surgery

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CONSENT FORM FOR RELEASE OF MEDICAL INFORMATION

I, _____, do hereby consent and authorize
(Patient's Name)

ALAMANCE EAR, NOSE AND THROAT, L.L.P. TO DISCLOSE ALL OF
PROVIDER'S RECORDS AND INFORMATION TO:

(Name of Provider)

(Address of Provider)

I consent to the disclosure of all medical records in the possession of the provider including, but not limited to records, reports or tests concerning alcoholism, drug use, emotional illness, psychiatric or mental disorders, abortions, symptoms or treatment of AIDS (Acquired Immune Deficiency Syndrome) including test results for the presence of HIV or an antibody to HIV.

If you wish to limit the material disclosed above in any way, please indicate exactly what you do not want released.

Patient's Signature:

Date of Birth:

Social Security #:

Telephone #:

Date:

Witness: