

**BREVARD EAR, NOSE AND THROAT CENTER  
MEDICAL AUTHORIZATION RELEASE REQUEST  
FAX (321) 639-7222**

Patient Name: \_\_\_\_\_ DOB : \_\_\_\_\_  
Address: \_\_\_\_\_ SS# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Cell#: \_\_\_\_\_

**PLEASE DO NOT LEAVE ANYTHING BLANK!**

I hereby authorize Brevard Ear, Nose and Throat Center to release my medical records to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Fax: \_\_\_\_\_

**OR** If you would like to be called and pick up the records in our office:  
Please Initial \_\_\_\_\_

Please be advised release of records may take up to **ONE** week before they are ready.  
**Charges:** All records that exceed 16 pages will be subject to a charge of \$1.00 per page.  
Any records required sooner than ONE week will be subject to a charge of \$1.00 per page.

**PLEASE MARK THE FOLLOWING:**

**RECORDS REQUESTED:**

All records: \_\_\_\_\_ Records 1 year prior to present **only:** \_\_\_\_\_  
Ct Films or disk: \_\_\_\_\_ Surgery report **only:** \_\_\_\_\_ Lab/Path report **only:** \_\_\_\_\_

Signature of Patient or Parent: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_